WISCONSIN HOSPITAL ASSOCIATION

ADVOCATE. ADVANCE. LEAD.

5510 Research Park Drive
P.O. Box 259038
Madison, WI 53725-9038
608.274.1820 | FAX 608.274.8554 | www.wha.org

TO: **Members of the Assembly Committee on Medicaid Reform and Oversight**

FROM: **Matthew Stanford, General Counsel**
Jon Hoelter, Director Federal & State Relations

DATE: **September 24, 2019**

RE: **WHA Supports AB 410 and Assembly Amendment 1 – Bipartisan Legislation to Modernize Medicaid's Telehealth Policies**

The Wisconsin Hospital Association supports AB 410 and Assembly Amendment 1, bipartisan legislation introduced by Representatives Loudenbeck and Kolste & Senators Kooyenga and Bewley that better leverages telehealth opportunities to improve access to care, enhance outcomes and reduce costs in the Medicaid program – especially for those living in underserved rural or urban communities.

In July, 90 lawmakers and staff attended a Capitol issue briefing from WHA, hosted by the same group of bipartisan co-authors spearheading Assembly Bill 410, which showed real-world barriers associated with Wisconsin's current Medicaid telehealth policies. Health care providers talked about their desire to expand cost-saving telehealth services to more patients, but current barriers in Medicaid prevent them from receiving Medicaid reimbursement for providing these services. Behavioral health care was one area in particular where providers noted outdated, unnecessary regulatory barriers have slowed or halted expanding access to behavioral health services through telehealth technology.

AB 410 is the result of recommendations from WHA's Telehealth Work Group, which included participation from more than 36 WHA rural, suburban and urban members across the state of Wisconsin. WHA's Telehealth Work Group has spent the past three years reviewing state laws and regulations while also engaging with DHS to find ways to leverage telehealth opportunities to improve access, enhance outcomes and lower costs for the Medicaid program. Through that review, the Work Group developed four recommendations articulated in this bill that will better align Wisconsin's Medicaid statute with past, current, and future advancements in telehealth:

1. **Treat Telehealth the same as in-person care.** Medicaid should allow all services it currently covers in person to be delivered via telehealth, if provided in a manner functionally equivalent in quality to an in-person visit.

2. **Catch up to Medicare telehealth-related coverage.** Medicare currently covers about 75 more telehealth-related procedure codes than Medicaid and tends to update new telehealth-related codes annually. Our work group recommended that it would be easier to offer telehealth services if clinicians knew both Medicaid and Medicare would cover the same telehealth-related services. This legislation would help Medicaid catch up and keep pace with Medicare in the new telehealth services it covers.

   Under this legislation and amendment, Medicare-covered, telehealth-related services automatically become reimbursable Medicaid covered services unless DHS promulgates a rule to exclude a Medicare-covered telehealth-related service.

3. **Cover in-home or community services.** Wisconsin's Medicaid program is one of only six states that does not allow for reimbursement in a home or community-based setting. Particularly for the Medicaid population, transportation challenges can be a significant barrier for accessing preventative and follow-up care that can avoid costly trips to an emergency department or hospitalization.

By enabling care through telehealth in a home or community-based setting, Wisconsin can improve outcomes and avoid high-cost health care utilization. In fact, WHA's In-Capitol briefing in mid-July provided concrete examples of hospital and health system members who are looking to add in-home telehealth options for Medicaid beneficiaries but have not yet because Medicaid doesn't reimburse for this care.

Under this legislation and amendment, in-home remote patient monitoring and asynchronous (store and forward) telehealth services are required to be reimbursable Medicaid covered services, unless DHS promulgates a rule excluding such service from reimbursement.

4. **Increase access to behavioral health.** Currently there is a statutory requirement that providers receive a separate telehealth certification, in addition to their provider licensure and Medicaid certification, if they want to provide behavioral health services via telehealth to Medicaid patients. No other health service covered by Medicaid requires a separate telehealth certification, creating an additional and unnecessary barrier to critically-needed behavioral health services.

   Under this legislation, the separate behavioral health telehealth certification is repealed. However, DHS may require by rule that the transmission of information through telehealth be of sufficient quality to be functionally equivalent to face-to-face contact.

Telehealth creates an opportunity for the Medicaid program to increase access and improve outcomes while maintaining or even reducing program costs.

Medicare, the State of Wisconsin Group Insurance Board, other states' Medicaid programs and private payers have embraced telehealth not only because it improves access to care, but because they have concluded that evidence shows utilization of telehealth improves access while maintaining or lowering the total cost of care.

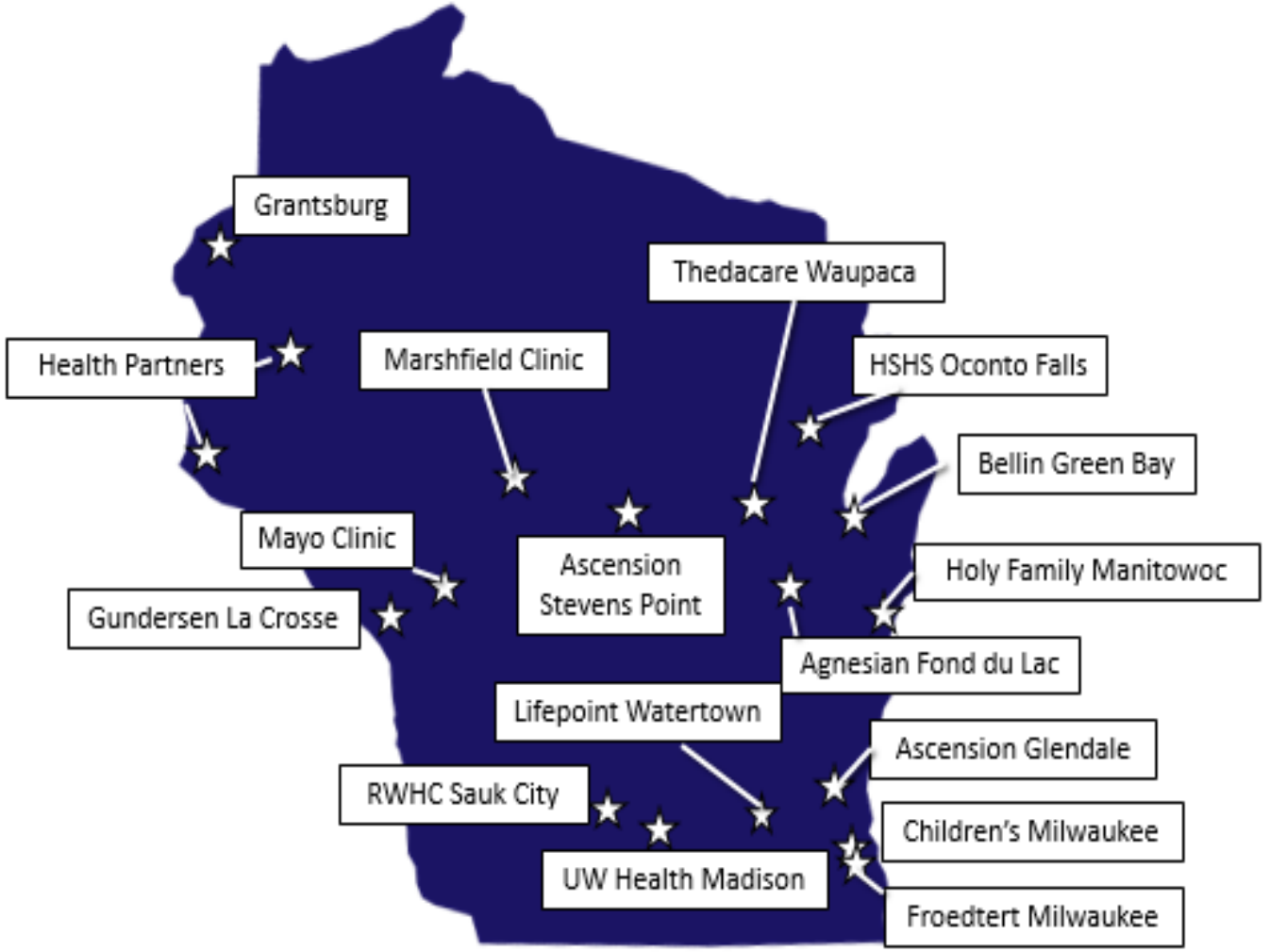
WHA has reviewed, compiled and attached to this testimony multiple sources of evidence that point to a conclusion that the expansion of telehealth services in the Medicaid program will result in no additional net program costs or will lower net program costs. Particularly for underserved Medicaid populations that have travel challenges and chronic conditions, having telehealth options enabled by this bill increases the likelihood that low-cost treatment and management services will be utilized to avoid high cost emergency or hospitalization services.

For example: an expecting, single mom who has a child at home may choose to skip her pre-natal appointment because she's struggling to fit it into her work schedule. Prenatal services, if provided through telemedicine to be delivered at home or even while at work, will provide a more flexible option for a mom trying to juggle a hectic schedule and make ends meet. This basic interaction can encourage prenatal care and help prevent an even more complicated pregnancy or delivery, which can cost the Medicaid program tens or even hundreds of thousands of dollars.

Additionally, telemedicine can directly reduce Medicaid expenditures for non-emergency medical transportation for Medicaid enrollees. On an annual basis, Wisconsin's Medicaid program pays $100 million to cover transportation costs for Medicaid enrollees – a cost that could be reduced by care being delivered via telemedicine rather than in person.

One primary goal you often hear from health care providers is to deliver "the right care, in the right place, and at the right time" to patients. We are pleased to support this bipartisan telehealth legislation that will advance that goal for patients throughout Wisconsin.

WHA Telehealth Work Group



36 WHA members participated, Representing hospitals and health systems from all over Wisconsin.

Appendix

Evidence on Cost Impacts for Telehealth Benefit Expansion Points to a Net $0 Impact or Cost Savings on Total Medicaid Benefit Costs

1) The Wisconsin Group Insurance Board concluded that telehealth coverage would not increase program costs.

In May 2018, the Wisconsin Group Insurance Board approved a change to the 2019 state employee health plan that would result in complete coverage of telehealth services. In calculating the cost of adding telehealth as a covered benefit, the Group Insurance Board budgeted the change as having an estimated net program cost of $0. Some argue that any new telehealth benefits might not accrue to a program in the form of reduced utilization of higher acuity and cost services for multiple years. However, the Group Insurance Board, which budgets on a year to year basis, rejected that theory when it estimated 2019 net costs at $0.

2) The Federal Medicare program has begun scoring the addition of telehealth benefits at $0 net cost.

In April 2019, the Medicare program published a final rule[i] implementing "additional telehealth benefits" for Medicare Advantage plans that resulted in HHS ultimately reaching the same conclusion as the Wisconsin Group Insurance Board – HHS scored the additional telehealth benefits as a net $0 impact on the cost of overall benefits.[ii]

Notably, the Medicare program drew on comments from the experience of Medicare Advantage insurers themselves to reach its conclusions regarding cost:

> We received numerous comments from several sources, and the commenters were overwhelmingly supportive. The comments were not subjective but evidence-based, reflecting MA plans' first-hand experience with telehealth in some of their existing products.[iii]
>
> Many of the commenters cited similar studies or their own experience. These articles and comments point to a quantitative savings in health care. Although, as mentioned previously, in the early years of telehealth there was concern for overutilization which would raise costs, this does not seem to be a major issue today.[iv]

Medicare noted one study that purported to show that telehealth increases costs; however, Medicare dismissed that study for several reasons:

> Only one article raised this [overutilization] concern, and the article itself listed several drawbacks to its conclusion. More specifically, the article –
> ++ Used data from only one telehealth company;
> ++ Used data on only specific medical conditions;
> ++ Referenced a population study that had a "low uptake of telehealth;" and
> ++ Was from an early period in telehealth.[v]

Conversely, Medicare provided examples of specific telehealth savings. For example, its review found that using telehealth for transitional care programs for discharged Medicare patients saved $1,333 per beneficiary, half of which was due to reduced inpatient follow-up care.

3) Telehealth coverage for Medicaid directly reduces unique Non-Emergency Medical Transportation costs for the Medicaid Program.

Unlike private insurance, the state employee health plan and Medicare, the Medicaid program provides a transportation benefit to Medicaid beneficiaries that has been an annual all funds expense of $100 million. Also,

unlike other health plans, every time a Medicaid enrollee substitutes a telehealth service – either from home or from a facility closer to home – Medicaid sees a direct cost reduction in the transportation benefit.

4) **California analysis of telehealth expansion in the Medicaid program found significant savings to the Medicaid Program.**

In 2011, California enacted the Telehealth Advancement Act that allows coverage of telehealth regardless of where it takes place, including programs that employ in-home telemonitoring devices. A cost analysis commissioned during consideration of the bill examined potential savings that would accrue to California's Medicaid program (Medi-Cal) regarding heart failure and diabetes management. It found that:

- In-home telemonitoring for heart failure patients could save $929 million annually for Medi-Cal ($8,600 per beneficiary per year).
- In-home telemonitoring for diabetics could save $417 million annually for Medi-Cal ($939 per beneficiary per year).[vi]

5) **Alaska began covering home telemonitoring of daily vital signs in 2007. They found a return on investment of nearly 1,500%.**

Beginning in 2007, Alaska implemented a home telemonitoring (HTM) program to mitigate substantial geographic barriers to care access in the largely rural state. In the first six years of the program, annual cost of care for program participants fell $634,365 (from $676,782 to $42,417 per year) through reductions in Medivacs, emergency room visits, and hospital readmissions.[vii]

6) **Colorado legislation in 2010 authoring reimbursement for remote monitoring received a fiscal note estimating savings to the Colorado Medicaid program.**

In 2010, Colorado's Medicaid program began reimbursing for "the remote monitoring of clinical data through electronic information processing technologies." The fiscal note affixed to the authorizing legislation estimated in-home telemonitoring would save Colorado Medicaid by reducing hospitalizations 10% and keeping Coloradans out of the emergency room.[viii]

7) **A study of Kansas telehealth expansion in the Medicaid program found $26,000 in cost savings per patient per year attributable solely from reduced hospitalizations.**

In 2010, the Center for Telemedicine & Telehealth at the University of Kansas Medical Center published the results from a three-year study tracking outcomes, costs, and utilization associated with Medicaid in-home telemonitoring services provided through a federal waiver. The results demonstrated the use of in-home telemonitoring reduced the rate of emergency room visits, inpatient hospitalizations, nursing facility placements, and associated health care costs. The authors of the study found over $26,000 in cost savings per patient per year from reduced hospitalizations. In comparison, the cost of equipment was $816 per patient per year.[ix]

8) **Louisiana's Department of Health and Hospitals examined available research and concluded that new telehealth applications reduce overall costs.**

In 2013, the Louisiana Department of Health and Hospitals wrote the following to the House and Senate Health and Welfare Committee chairmen:

> Research cites three methods telehealth can produce an economic benefit. The first is patients can avoid hospital transfers by receiving telehealth consultation services, therefore reducing transportation expenses. In emergency situations, like stroke care, telehealth can provide guidance to physicians to administer life-saving drug therapy. The second method is home monitoring of patients with chronic diseases which can result in decreased hospitalizations. Finally, telehealth can enhance the marketability of rural health facilities and keep more health care dollars in the local economy…In addition to telehealth economic benefits, results in patient

health outcomes have been optimal. Recent studies have found that new telehealth applications, such as remote patient monitoring, have reduced overall costs, and improved health outcomes for target populations.[x]

9) A New York Study of 53 patients with high hospital utilization found telehealth produced a 42% drop in medical costs.

In 2010, the New York Eddy Visiting Nurse Association (VNA) completed a one-year study of 53 patients with two or more hospitalizations or emergency room visits in the last 12 months that had telehealth units installed in their homes. The study reported the following results:

- 55% drop in the number of hospitalizations, from 178 to 80;
- 29% reduction in emergency visits, from 137 to 97;
- 42% drop in medical costs, from $3 million to $1.7 million.[xi]

10) In 2013, Texas authorized Medicaid coverage of in-home telemonitoring services. In the fiscal note authorizing that coverage, the Deputy Executive Commissioner for Financial Services for the Texas Medicaid program concluded the change would result in cost savings.

The fiscal note determined that the first five-year period of the new coverage would result in cost savings "as the addition of telemonitoring as a Medicaid benefit is anticipated to result in fewer hospital readmissions and emergency room visits." The note did not identify exact savings that would accrue, but "the report unequivocally states the policy would result in anticipated cost savings."[xii]

11) A study of Iowa's use of telehealth for congestive heart failure management found nearly $3m in savings in a demonstration program for the Iowa Medicaid program.

A demonstration project of 266 Iowa Medicaid members utilizing telehealth in the management of congestive heart failure found a 24% reduction in hospital admissions, a 22% decrease in total bed days, and nearly $3m in savings from reduced health care service utilization. [xiii]

12) A 2015 study concluded that telehealth for individuals with mental health needs improves care and reduces costs.

A study by researchers at the University of Michigan, University of Kentucky, and University of California Davis concluded:

> "The published scientific literature on [telemental health] reveals strong and consistent evidence of the feasibility of this modality of care and its acceptance by its intended users, as well as uniform indication of improvement in symptomology and quality of life among patients across a broad range of demographic and diagnostic groups. Similarly, positive trends are shown in terms of cost savings. Conclusion: There is substantial empirical evidence for supporting the use of telemedicine interventions in patients with mental disorders."[xiv]

---

[i] Department of Health and Human Services, "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021," 84 Fed. Reg. 15680 (April 16, 2019) https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

[ii] HHS did score a $6.1m and $6.1m cost to the Medicare Trust Fund in 2020 and 2021 respectively due to the additional telehealth benefits in the rule for approximately 22 million beneficiaries. However, HHS explains that those costs are not due to the additional benefits but from a transfer of costs from rebates to the Medicare Trust Fund because of a change in classification of the benefits from supplemental benefits to basic benefits.

[iii] Id at 15811.

[iv] Id.

[v] Id. at 15810- 158112.

[vi] Connecticut General Assembly (CGA). 2015. Survey of states providing coverage for in-home telemonitoring services. Hartford, CT: CGA.

https://www.cga.ct.gov/hs/tfs/20151008_Medicaid%20Rates%20for%20Home%20Health%20Care%20Working%20Group/20151109/Survey%20of%20States%20Providing%20Coverage%20for%20Telemonitoring.pdf

[vii] Id.

[viii] Id.

[ix] Id.

[x] Id.

[xi] Id.

[xii] Id.

[xiii] http://www.iowaccc.com/wp-content/themes/iccc/pdf/Congestive_Heart_Failure.pdf

[xiv] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4744872/pdf/tmj.2015.0206.pdf