WISCONSIN HOSPITAL ASSOCIATION

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November 6, 2019

The Honorable Ron Johnson
United States Senate
Washington, DC 20510

The Honorable Tammy Baldwin
United States Senate
Washington, DC 20510

The Honorable James Sensenbrenner
U.S. House of Representatives
Washington, DC 20515

The Honorable Ron Kind
U.S. House of Representatives
Washington, DC 20515

The Honorable Gwen Moore
U.S. House of Representatives
Washington, DC 20515

The Honorable Mark Pocan
U.S. House of Representatives
Washington, DC 20515

The Honorable Glenn Grothman
U.S. House of Representatives
Washington, DC 20515

The Honorable Mike Gallagher
U.S. House of Representatives
Washington, DC 20515

The Honorable Bryan Steil
U.S. House of Representatives
Washington, DC 20515

Dear Members of Wisconsin's Congressional Delegation,

Thank you for meeting with the Wisconsin Hospital Association in Washington, DC last week. As our group mentioned, new legislation to modernize Medicare's outdated telehealth policy has now been introduced and WHA needs your support.

Removing barriers that prevent health care providers from using telehealth to its full potential has been a major priority for WHA at both the state and federal levels. At the state level, WHA has partnered with a group of bipartisan legislators to advance major telehealth Medicaid reform legislation that will remove current government barriers to care. This legislation is the result of three years of work from WHA's Telemedicine Work Group. WHA has worked hard to gather the support of 67 state legislators and the Wisconsin Department of Health Services in crafting this important telehealth Medicaid modernization legislation. Among other things, it will allow Wisconsin health care providers to offer any in-person Medicaid covered service via telehealth if it can be provided in a functionally equivalent manner as a face-to-face visit. It will also allow Medicaid to cover telehealth services in any setting, rural or urban, including in a patient's home.

While we are excited to remove these barriers to care at the state level, we now need your help to remove similar barriers at the federal level. Medicare currently will not reimburse for telehealth services unless the patient physically travels to an approved health care facility, and even then, only if that facility is located in a rural, health professional shortage area. This imposes significant limitations on the ability for health care providers to use telehealth to improve care in Wisconsin's Medicare population. Congress has wisely begun to start adding certain telehealth services that Medicare will reimburse for in any setting, including stroke care, renal disease, and certain substance-use and co-occurring behavioral health services.

This is a start, but much more needs to be done to remove government barriers for other important telehealth services.

For example, a hospital today may be ready to discharge a Medicare patient who no longer needs hospital care, but will need follow-up care. In circumstances where that patient lives alone and may not have a good support system, they may need to be transferred to a nursing home or even stay in the hospital longer than necessary to ensure they get the follow-up care they need to continue their recovery. Alternatively, in circumstances where a patient can be sent home, they may need to travel a significant distance back to the hospital or other clinic for follow-up care. Imagine if Medicare could cover these follow-up home care services via telehealth. It would actually save Medicare dollars by allowing providers to deliver this care in a more cost-effective setting, and in a more convenient manner for patients.

Today, we are asking you to sign on as a cosponsor to legislation that will help advance telehealth innovation for Medicare patients. The CONNECT for Health Act of 2019 has been introduced by a bipartisan group of legislators in the House and Senate as H.R. 4932 and S. 2741. While the bill will not remove all of the barriers previously mentioned, it will continue to build momentum toward their eventual removal. Some of the highlights include:

- Stating that Congress has found research suggesting telehealth can expand access to care, reduce workforce shortages, improve the quality of care, and reduce spending.
- Expressing the sense of Congress that barriers to telehealth should be removed.
- Allowing the Secretary of Health and Human Services to waive barriers to telehealth if certain criteria are met.
- Allowing behavioral health telehealth to be covered by Medicare in any setting (urban and rural) including in a person's home.
- Removing geographic barriers by allowing EMS telehealth services to be covered in both rural and urban settings.
- Allowing telehealth to be delivered by and originate at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics
- Providing flexibility for telehealth in hospice care.
- Requiring the Medicare Payment Advisory Commission (MEDPAC) to study the benefits of allowing Medicare to cover telehealth delivered to a patient's home.

WHA is aware that the Congressional Budget Office scoring methodology can be a significant barrier when it comes to advancing legislation perceived as expanding health care utilization. It is important to understand that telehealth is not a new benefit, but, rather, an alternative way of accessing current benefits. WHA has compiled a number of examples that suggest any increases in utilization can be offset by enabling more efficient care in lower cost settings that help avoid expensive and unnecessary hospital admissions or reduce the overall amount of time a patient spends in a higher-cost setting. Please see the attached appendix for details.

But don't just take my word for it. I encourage you to take the opportunity to tour your local hospitals the next time you are back in your district and see firsthand just what telehealth services they currently offer or are looking to offer in the future. Please contact Jon Hoelter, WHA's Director of Federal and State Relations at jhoelter@wha.org or 608-268-1819 with any questions.

Thank you, and I look forward to your support of this important legislation that will help modernize Medicare, improve access to care, and help Wisconsin continue to build on its reputation as a national leader in health care quality.

Sincerely,

Eric Borgerding
Wisconsin Hospital Association
President and CEO

attachment

Appendix

Examples of Telehealth Efficiencies Decreasing Health Care Costs

1) Drawing on the experience of private Medicare Advantage plans, CMS has begun to recognize that private health insurers are adding telehealth benefits without projecting large cost increases.

In April 2019, the Medicare program published a final rule[i] implementing "additional telehealth benefits" for Medicare Advantage plans that resulted in HHS not assigning a cost increase to new added 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.

2) 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.

3) Telehealth can reduce transportation costs in both Medicaid and Medicare.

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 ($40 million in state and $60 million in federal funding). 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. While Medicare does not reimburse for nonemergency medical

transportation there are some telehealth emergency services that would reduce costs associated with emergency travel. Telehealth can also save travel costs for Medicare beneficiaries on fixed incomes.

4) **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."[vi]

5) **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. [vii]

6) **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."[viii]

7) **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).[ix]

8) **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.[x]

9) **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.[xi]

10) **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.[xii]

11) **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.[xiii]

12) **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.[xiv]

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[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] Id.

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

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

[ix] 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

[x] Id.

[xi] Id.

[xii] Id.

[xiii] Id.

[xiv] Id.