Breaking Down Barriers to Access

The Healthcare Leadership Council (HLC) supports reexamining restrictive reimbursement and regulatory barriers that make it challenging to use telehealth. Telehealth has been shown to improve healthcare quality and lower costs, while giving more people access to quality healthcare. Telehealth is already available in some circumstances, but expanding it to serve an even larger population is needed to further increase access to quality care.

Benefits of Telehealth
- Increased access to telemedicine would make it easier for providers to treat patients and improve continuity of care and care coordination by:
  - Increasing access to medical care for beneficiaries unable to travel.
  - Addressing provider shortages in rural or other areas.
- Telemedicine has been shown by HLC members to improve healthcare quality and lower costs, while giving more people access to quality healthcare.
- Numerous studies on telehealth and remote patient monitoring (RPM) have shown benefits in quality care and cost savings. (see: http://cchpca.org/research-catalogues)

Current Telehealth Restrictions
- Regulatory barriers make it challenging to use telemedicine.
- Collectively, these are often referred to as “1834(m) restrictions” – and they include: limitations on the type of services provided, geographic location, the type of clinical site the patient is located in, type of institution delivering the services, and type of health provider.
- Store-and-forward technology (e.g., email) is not reimbursable except in Alaska and Hawaii, where it is permitted as part of a federal demonstration program.
- While RPM is already available in some circumstances, lack of common procedure terminology (CPT) codes and the requirement that RPM activities be bundled into other payments prevent their widespread use.

HLC Position
- HLC strongly supports the lifting of the “1834(m) restrictions” that prevent the widespread use of telehealth in Medicare.
- In Medicare Advantage, HLC strongly supports telehealth’s inclusion as part of the basic benefit package and not limited to supplemental benefit funds available.
- HLC believes payment for telehealth services should always connect to the type of service being provided, not the method by which it is provided, so providers are able to choose the means which is most effective for each patient. Telehealth is a medical practice tool, not a separate form of medicine, and any definition should be technology neutral.
CONNECT for Health Act  
(S. 2484 / H.R. 4442)  

Expanding Use of Telehealth in Medicare  

Promoting cost savings & quality care in Medicare through telehealth and remote patient monitoring

**The Latest:** Sponsors of the CONNECT for Health Act are working on gathering more cosponsors (currently at 6 Republicans and 6 Democrats in the Senate and 10 Republicans and 20 Democrats in the House as of July 14, 2016).

**Broad Support**
- Introduced by Senators Schatz (D-HI), Wicker (R-MS), Cochran (R-MS), Cardin (D-MD), Thune (R-SD), and Warner (D-VA) and Representatives Black (R-TN), Harper (R-MS), Welch (D-VT), and Thompson (D-CA).
- More than 50 supporting organizations spanning all sectors of healthcare including plans and providers as well as physician groups, patient organizations, academic centers, and many others.

**The CONNECT for Health Act would:**
- Create a bridge program to help providers transition to the goals of the Medicare Access and CHIP Reauthorization Act (MACRA) and the Merit-based Incentive Payment System (MIPS) through using telehealth and remote patient monitoring (RPM) without most of the current regulatory restrictions that limit the use of telehealth based on type of services provided, geographic location, the type of clinical site the patient is located in, type of institution delivering the services, and type of health provider (“1834(m) restrictions”);
- Allow telehealth and RPM to be used by qualifying participants in alternative payment models, without most of the aforementioned 1834(m) restrictions;
- Permit the use of remote patient monitoring for certain patients with chronic conditions;
- Allow, as originating sites, telestroke evaluation and management sites; Native American health service facilities; and dialysis facilities for home dialysis patients in certain cases;
- Permit further telehealth and RPM in community health centers and rural health clinics;
- Allow telehealth and RPM to be basic benefits in Medicare Advantage, without most of the aforementioned 1834(m) restrictions; and
- Clarify that the provision of telehealth or RPM technologies made under Medicare by a health care provider for the purpose of furnishing these services shall not be considered “remuneration.”

**Potential for Cost Savings**
- The bill includes requirements regarding cost containment, quality measures, and data collection.
- An Avalere analysis of three of the major provisions of the bill (first three bullets above) showed $1.8 billion in savings over 10 years. Savings resulted from reduced hospitalizations due to the use of RPM. The analysis estimates that in Fiscal Year 2017, a total of 14.7 million Medicare beneficiaries will be using telehealth services and 3.3 million beneficiaries will be using RPM.
The TELEmedicine for MEDicare (TELE-MED) Act

• The bipartisan legislation allows Medicare providers to treat patients electronically across state lines without having to obtain multiple state medical licenses.
• The bill also includes provisions that would direct the HHS Secretary to issue guidance to states to develop a definition of “telemedicine services” using input from relevant stakeholders including patients, health care providers, State government officials, health technology developers, insurers, employers, licensing boards, community health organizations, and other Federal agencies.

Benefits: Expanded Access, Improved Patient Outcomes, Lower Healthcare Costs

Access
• Medicare beneficiaries are often not able to travel to receive care due to distance, health, transportation, financial, or mobility issues.
• Provider shortages (particularly in certain specialties) may make it even more difficult to access necessary care.
• Decreased access of beneficiaries increases healthcare costs overall by making it difficult for patients to obtain the best care and treatment.

Improved Patient Outcomes and Lowered Healthcare Costs
• Telehealth can promote care coordination, care continuity, and prevention—all of which improve health outcomes and lower health costs for the system.
• Emergency situations can be assessed via telemedicine, which can reduce inappropriate use of emergency departments.
• Preventive measures and treatment plan adherence can be monitored via telemedicine, increasing long term health and decreasing long term costs.
• Improved health outcomes would lower overall costs as patients received continuous intervention rather than miss or skip appointments, treatment, and preventive care that could result in higher use of emergency departments and other costly health services later on.
• Numerous studies on telehealth and RPM have shown benefits in quality care and cost savings (http://cchpca.org/research-catalogues).
• Medicare spending needs to be reduced, and utilizing telemedicine for Medicare beneficiaries will help in accomplishing this goal.
The Expanding Capacity for Health Outcomes (ECHO) Act (S. 2873)

Connecting Specialists with Primary Care Providers in Underserved Areas

The Latest: After introduction this spring, the ECHO Act has 6 Democratic and 3 Republican cosponsors in the Senate as of July 14, 2016.

Rural Health Challenges
• Only about 10 percent of physicians practice in rural areas of the U.S. despite nearly one-fourth of the population living in these areas.
• Rural areas have higher rates of some chronic diseases and face many challenges, including transportation, connectivity, and isolation.
• It is difficult to recruit health care providers to work in rural and underserved areas, and there can be fewer opportunities for professional development and support in such areas.

Project ECHO Model
• Project Extension for Community Health Outcomes (ECHO) is an innovative continuing medical education model that uses interactive videoconferencing to link specialist teams (“hubs”) with primary care providers (“spokes”) in rural and underserved areas. Together, they participate in weekly teleECHO clinics that combine didactic teaching with mentoring and case-based learning.
• Demonstrated uses of Project ECHO have been numerous and include:
  • Addressing disease conditions and topic areas, including hepatitis C, integrated addictions and psychiatry, chronic pain/headache management, and diabetes;
  • A complex care program offering support to multidisciplinary teams providing primary and behavioral health care to high-need, high-cost patients; and
  • Public health interventions, including addressing H1N1, HIV, and tuberculosis as well as improving health and wellness within Native American populations.

Benefits of Project ECHO model for:
• Patients: Improved access to quality and accessible care, with high patient satisfaction
• Providers: Increased knowledge for providers in rural/underserved areas, with ability to serve as a local resource; improved provider network; enhanced professional satisfaction and reduced isolation; more access to specialists.
• Health care system: Higher retention of providers in rural/underserved areas; better care delivered in the right place at the right time by the right person; decreased costs (less travel for specialty visits, less hospitalizations and ER visits, better quality of care close to home, and treatment of chronic diseases earlier before complications arise).
• Current health care challenges: Project ECHO has successfully been used to increase the number of physicians able to prescribe buprenorphine for opioid abuse, to quickly educate health providers on public health crises such as H1N1, and to train providers to address complex mental health disorders.
S. 2873, the Expanding Connectivity for Health Outcomes (ECHO) Act

The ECHO Act aims to better integrate the Project ECHO model—referred to as a “technology-enabled collaborative learning and capacity-building model”—into health systems across the country. The bill:

- Requires the Secretary of the U.S. Department of Health and Human Services (HHS), in collaboration with the Health Resources & Services Administration (HRSA), to prioritize analysis of the model, its impacts on provider capacity and workforce issues, and evidence of its effects on quality of patient care.
- Requests a GAO report regarding opportunities for increased adoption of such models, efficiencies and potential cost savings from such models, ways to improve health care through such models, and field recommendations to advance the use of such models.
- Requires the HHS Secretary to submit a report to Congress on the findings of the GAO report and the HHS report, including ways such models have been funded by HHS and how to integrate these models into current funding streams and innovative grant proposals.