



Information Technology Industry Council
Leading Policy for the Innovation Economy



January 26, 2010

President Barack Obama
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

The Honorable John Boehner
Minority Leader
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Mitch McConnell
Senate Minority Leader
United States Senate
Washington, D.C. 20515

The Honorable Harry Reid
Senate Majority Leader
United States Senate
Washington, D.C. 20510

Dear President Obama, Speaker Pelosi, and Leaders Reid, McConnell and Boehner:

As you debate the path forward for healthcare reform, the co-signers representing patients, hospitals, providers and technology companies, urge you to focus on the role technology can play in offering solutions that will improve care through cost effective measures. We recommend that you retain and expand those pieces of the House and Senate proposals which recognize the value of integrating telehealth and remote monitoring/diagnostics to ensure that better care is delivered at lower cost. We have highlighted below the existing reform measures that will meet these objectives and added three proposed modifications to the House and Senate bills that, if implemented, would further improve health in America.

1. Independence at Home Act - Creates an Independence at Home pilot in which teams coordinate all aspects of patient care, and are required to "use electronic health information systems, remote monitoring, and mobile diagnostic technology" as patient appropriate.

2. Accountable Care Organizations - Requires coordinated care team to "define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies."

3. CMS Innovation Center - Appropriates \$10B for the CMS Innovation Center that would require that CMS test payment models that "support care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization through a health IT-enabled network that includes a chronic disease registry, home tele-health technology, and care oversight by the beneficiary's treating physician." The model criteria

also must "utilize technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings." The Senate Freshmen Moderates added remote monitoring pilots for Indian health, behavioral health and stroke patient care.

4. Health Homes for Chronic Conditions – Allows states to provide health homes for enrollees with chronic conditions; requires state plan to include a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology). Healthcare professionals as a team may be virtual, free standing, etc.

5. Creation of a Telehealth Advisory Committee to Advise HHS Secretary.

Recommendations for Additional Provisions

Reducing Hospital Admissions

We recommend adding remote patient monitoring to *Section 3026 "Hospital Readmissions Program"* of the Senate's health care reform legislation. Section 3026 addresses the transition from hospital to home for often fragile and chronically ill patients. Remote patient monitoring has proven effective in assisting providers to avoid hospital readmissions by providing real time information concerning the patient's health after discharge from an institutional care setting. (Please see suggested language in attachment.)

The Department of Veterans Affairs studied this issue in their report, "Care Coordination/Home Telehealth: The Systemic Implementation of Health Informatics, Home Telehealth and DM to support the Coordination of Veteran Patients with Chronic Conditions." The VA found that implementing telehealth to coordinate patient care led to a 25 percent reduction in the number of bed days and a 20 percent reduction in hospital admissions. The report showed a cost of \$1,600 per patient per annum for the telehealth program compared to \$13,121 for primary care and \$77,745 for nursing home care. Not only were patients able to avoid readmissions and improve their health status faster through telehealth services, taxpayers saved money.

Likewise, the New England Healthcare Institute's *2008 Research Update, Remote Physiological Monitoring*, found a 60% reduction in hospital readmissions using remote patient monitoring compared to standard care and a 50% percent reduction in hospital admissions using remote patient monitoring compared to disease management programs without remote monitoring. In addition, this report estimates remote patient monitoring has the potential to prevent between 460,000 and 627,000 heart failure related hospital admissions each year.

National Pilot Program on Payment Bundling

Based on the studies referenced above, telehealth is a viable alternative for care delivery and should be included as a care plan in the national pilot program on payment bundling as part of the post-acute care services including home health services, skilled nursing, and inpatient services found in Section 3023. (Please refer to attachment.)

Physician Credentialing and Privileging

Hospital telehealth networks are facing a death threat by new but outmoded CMS staff re-interpretations of Medicare regulations regarding the credentialing and privileging of medical staff.

Requiring full-scale credentialing and privileging for all telehealth services will be too costly and time-consuming, especially for small hospitals most in need of telehealth services. A House provision goes part way by directing revised CMS guidance on credentialing. However, privileging is an equally burdensome process. Addressing one without the other is not adequate – like an authorization without an appropriation. We urge the final version include the House provision (section 1191(c)) and be extended to privileging.

Summary

Our aging population is creating an increased demand for health services. At the same time, our nation is facing a shortage of health care providers from nurses, pharmacists to primary care providers. The health care labor shortage is expected to last through 2050. Almost half of the health care workforce was 45 years or older by 2008. The shortage of providers hits rural areas particularly hard. Given these facts, our health care delivery system needs innovative models of care that will leverage our current workforce and improve care.

Studies have documented technology's ability to improve care and save health care dollars when combined with individual coordinated care plans. Remote patient monitoring and similar technologies can play an important role in enhancing care and should be incorporated into every aspect of a reformed healthcare system.

We strongly believe that remote patient monitoring is a key ingredient in providing delivery service reforms that will change the opportunities for our aging community to remain at home with daily attention to their chronic disease. We urge you to support its inclusion in the final healthcare reform legislation.

Sincerely,

American Association of Homes and Services for the Aging (AAHSA)

America Telemedicine Association (ATA) AT&T Center for Aging Services Technologies (CAST)

Christus Health Continua Health Alliance HIT Now Coalition

Information Technology Industry Council Intel Microsoft National Family Caregivers Association

Older Americans Technology Services (OATS) Oracle Polymap Wireless Qualcomm

Samsung TechAmerica Vignet

Recommended Legislative Language
for Telehealth Solutions for Healthcare Reform

National Pilot Program on Payment Bundling

The current legislative text in HR 3590 (see below) should be amended to include “telehealth and remote patient monitoring services” after “home health services” to complete the continuum of care already captured in that sentence.

SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

“(C) APPLICABLE SERVICES.—The term ‘applicable services’ means the following:

“(i) Acute care inpatient services.

“(ii) Physicians’ services delivered in and outside of an acute care hospital setting.

“(iii) Outpatient hospital services, including emergency department services.

“(iv) Post-acute care services, including home health services, **telehealth and remote patient monitoring**, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

“(v) Other services the Secretary determines appropriate.

Reducing Hospital Admissions

Section 3026 of H.R. 3590 creates the Community-Based Care Transitions Program. This section concerns the transition from hospital to home for often fragile and chronically ill patients. We believe that remote patient monitoring would assist providers in avoiding hospital readmissions and obtaining real time information concerning a patient’s health. Thus, we recommend the addition of remote patient monitoring to Section 3026. This could be included by **adding “(vi) Monitoring a high-risk Medicare beneficiary through the use of telehealth and remote patient monitoring services.” after Section 3026(c)(2)(B)(v).**

Physician Credentialing and Privileging

Hospital telehealth networks are facing a death threat by new but outmoded CMS staff re-interpretations of Medicare regulations regarding the credentialing and privileging of medical staff. Requiring full-scale credentialing and privileging for all telehealth services will be too costly and time-consuming, especially for small hospitals most in need of telehealth services. A House provision goes part way by directing revised CMS guidance on credentialing. But, privileging is an equally burdensome process. Addressing one without the other is not adequate -- like an authorization without an appropriation. We urge the final version include **the House provision (section 1191(c)) and be extended to privileging.**