American Heart Association | American Stroke Association
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Advocacy Department
1150 Connecticut Ave., NW | Suite 300 | Washington, DC 20036
P 202-785-7900 | F 202-785-7950 | www.heart.org

January 26, 2015

The Honorable Fred Upton
Chairman
Committee on Energy & Commerce

The Honorable Frank Pallone
Ranking Member
Committee on Energy & Commerce

The Honorable Gregg Harper

The Honorable Peter Welch

The Honorable Bill Johnson

The Honorable Doris Matsui

The Honorable Bob Latta

The Honorable Greg Walden

Dear Chairman Upton, Ranking Member Pallone, and Representatives Harper, Welch, Johnson, Matsui, Latta, and Walden:

Thank you for your interest in the issue of telehealth and for releasing discussion draft legislation intended to expand Medicare coverage for telehealth services as part of the 21st Century Cures initiative. The American Heart Association/ American Stroke Association applauds you for your leadership in seeking to modernize Medicare by improving beneficiaries' access to telehealth by removing current Medicare barriers to their reimbursement.

While we appreciate your efforts and believe the draft is a positive first step, we are convinced that there is much more Congress can and should do to address the current barriers without increasing federal government spending. **In particular, we strongly urge the Working Group to eliminate the rural originating site requirement specifically with respect to the delivery of high quality stroke care delivered via telehealth**, as is proposed in Section 105 of the bipartisan Telehealth Enhancement Act of 2013 (HR 3306), introduced by Representatives Harper, Welch, Mike Thompson, and others. We are very hopeful that the Congressional Budget Office (CBO) will find that such a narrowly-crafted provision will not increase federal health care expenditures and may even result in modest cost savings by reducing stroke patients' need for inpatient rehabilitation and nursing home care.

Numerous studies have demonstrated that the use of telemedicine in the treatment of stroke – now commonly referred to as "telestroke" care − can be tremendously helpful in improving access to high quality stroke care. Stroke is the fifth leading killer of Americans, and leading causes of serious, long-term disability and dementia. Approximately 795,000 people experience a stroke each year in the United States, and about 66 percent of the total hospitalizations for stroke occur among adults ages 65 and older.

Every minute matters when treating stroke. The recommended treatment for acute stroke must begin as soon as possible after symptom onset to be most effective and reduce disability but within no longer than 3 to 4-1/2 hours of the onset of stroke signs or symptoms. There are, however, a number of barriers that prevent patients from receiving acute treatment within this critical timeframe, including long distances to tertiary care hospitals and a shortage of neurologists. As a result of these and other barriers, only 3-6 percent of patients receive the clot-busting treatment recommended by the latest scientific guidelines for acute stroke.

The use of telestroke has shown great promise in improving patient access to recommended stroke treatments in rural and other "neurologically underserved" areas, including urban areas with low stroke thrombolysis treatment rates. Moreover, the outcomes for stroke patients who are cared for in hospitals with telemedicine support have been comparable to those achieved in more conventional tertiary care settings and have surpassed those achieved by general hospitals without telemedicine support or stroke units.

Despite the proven benefits of stroke telemedicine, Medicare's rural originating site requirement continues to serve as a barrier to using telestroke to provide high quality stroke care to the 94 percent of Medicare beneficiaries who have a stroke who live in urban and suburban areas. Many areas of the country – including some urban and suburban areas – do not have appropriate access to acute stroke care. There are roughly four neurologists per 100,000 people in the United States treating the nearly 800,000 new or recurrent strokes that occur each year. Telestroke has proven to be an effective means of helping provide high-quality stroke care in non-rural areas.

In addition to improving access to the recommended care, we believe the greater use of telestroke will also result in savings to the federal government by reducing disability and the need for more extensive medical care. According to a study published in the *New England Journal of Medicine*, stroke patients receiving clot-busting therapy were at least 30 percent more likely to have minimal or no disability at three months, compared to patients who did not receive this treatment. These patients also have shorter hospital stays and are more frequently discharged to their homes rather than to rehabilitation centers or nursing homes. In addition, the Veterans Administration Stroke Study (VAST) showed that neurologist care for acute stroke patients, which can be provided via telemedicine when local neurological expertise is lacking, was associated with lower in-hospital mortality and less long-term disability. We have attached a memo developed at the request of CBO, further outlining why we believe expanding Medicare coverage of telestroke to urban and suburban areas can be done without increasing federal spending. We have also attached proposed legislative language to make this change, which is based on the provision in the Telehealth Enhancement Act.

In addition to explicitly requiring Medicare to cover telestroke services in urban and suburban areas, we also encourage the Telehealth Working Group to consider the following additional modifications to its discussion draft:

- In general, while we greatly appreciate that the Working Group is proposing a framework for eliminating many of the originating site and geographic restrictions for specific services at the discretion of the Health and Human Services (HHS) Secretary, we are concerned that HHS will not use this authority. HHS and the Center for Medicare and Medicaid Services (CMS) has had the authority to expand covered telehealth services since 2000, but so far has added very few services. Likewise, HHS has the authority to waive *any* statutory restriction on telemedicine in demonstrations conducted

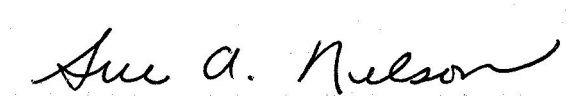
by CMS, but has so far elected not to do so. Therefore, rather than leaving it up to the CMS Chief Actuary to certify services for coverage, we support the approach that we understand are being proposed by the Alliance for Connected Care and the American Telemedicine Association to have an independent federal advisory committee make recommendations for the services to be added, using specified criteria.

- We also urge the Task Force to ensure that the payment framework for telehealth services can work for episodes of care where telehealth is being used for evaluation to improve the quality of care being provided, not substituting for an in-person encounter. As described above with respect to the use of telestroke, telehealth evaluations that complement an in-person encounter and ultimately improve the quality of care and reduce (or do not increase) federal spending should also be eligible for coverage, as appropriate based on the medical evidence. However, in such cases, it may not be appropriate to automatically reimburse for the telehealth evaluation at the same amount as Medicare would pay for the in-person visit. The use of technology in health care can lower costs, and this should be taken into consideration when developing reimbursement rates for services provided via telehealth.

- Finally, in defining the criteria that should be considered when adding coverage for telehealth services, we recommend that the Task Force change the language on page 4, line 13 and on page 6, line 13 from “net program spending” to “net federal spending” or “net federal health care spending”. This would allow for the addition of services that can be shown to ultimately reduce federal spending on disability payments and long-term nursing home care, as is the case with telestroke.

Thank you for your consideration of our comments. We look forward to continuing to work with the Task Force on the telehealth provisions and the 21st Century Cures initiative more broadly.

Sincerely,



Sue A. Nelson
Vice President, Federal Advocacy

Enclosures