

AMERICAN WELL™

The Honorable Joe Pitts
Chairman
House Energy and Commerce Committee
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
Subcommittee on Health
2322A Rayburn House Office Building
Washington, DC 20515

RE: Responses to Questions for the Record regarding "Telehealth to Digital Medicine: How 21st Century Technology Can Benefit Patients"

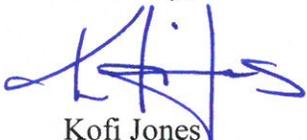
Chairman Pitts and Ranking Member Pallone:

Thank you again for the opportunity to appear before the Subcommittee on Health on May 1, 2014, to testify on how advances in technology can be harnessed to advance our nation's health care system and how the federal government can support technology adoption in our health care programs to reduce costs and increase the overall quality and efficiency of programs.

Below please find American Well's response to the questions for the record requested by the Subcommittee.

Thank you for your consideration.

Sincerely,



Kofi Jones
Vice President of Public Affairs
American Well

The Honorable Joseph R. Pitts

1. What role can telemedicine play to facilitate new payment models?

Telemedicine can reduce in-office, consumer out-of-pocket, and payer costs; increase access to underserved areas, primary care and evaluation, specialty care, health management, and care-coordination; avoid unnecessary hospitalizations and emergency room (ER) visits; and minimize excessive patient wait times and transportation costs. Telemedicine can also assist providers to prevent and slow the onset of a disease to the point where it becomes chronic and more costly.

Thus, telemedicine is a tool that obviates barriers to efficiency and access. Since telemedicine can provide high touch, high frequency care for high risk individuals in the lowest cost setting and environment that many patients and providers prefer, it furthers new payment models that leverage these attributes into aligning payments to incentivize the delivery of higher quality, lower cost, and coordinated care.

The value proposition for telemedicine as a key part of payment model reform was recognized in a recent, bipartisan amendment offered by Senators John Thune (R-SD), Ron Wyden (D-OR), Pat Roberts (R-KS), Jay Rockefeller (D-WV), Mike Enzi (R-WY), and Debbie Stabenow (D-MI) to the Senate Finance Committee's markup of the *SGR and Medicare Beneficiary Access Improvement Act*. This amendment would have promoted the use of telehealth technology by ensuring payment and eligibility barriers to using telehealth under Medicare do not exist in Alternative Payment Models (APMs) – e.g. accountable care organizations (ACOs), patient centered medical homes, bundled payment models, etc. It would have ensured that the geographic and statutory restrictions on Medicare reimbursement in Social Security Act Section 1834(m) would not apply to APMs. Unfortunately, this amendment was not included in the final language for the short-term SGR patch that was recently signed into law.

Furthermore, in countries where telemedicine has matured more quickly (due to fewer governmental barriers), payment reform has already begun. For example, a Deloitte paper, "Technology, Media, and Telecommunications Predictions 2014," outlines that in Ontario, Canada, the government recently added a public insurance payment code to allow physicians to bill for "e-consults". Australia and France have long allowed for government support for electronic health care visits, and Denmark has also offered telemedicine reimbursement for many years and is piloting new variations—such as telepsychiatry.

2. What payment models are likely to best encourage the development of telemedicine or benefit from the use of telemedicine and how?

As telemedicine furthers new payment models that leverage the dual benefits of efficiency and access, payment models that align payments to incentivize the delivery of higher quality and lower cost care will further the development of telehealth. Models that

prioritize three main areas will be important to telemedicine: 1) Access; 2) Specialized Populations; and 3) Payment Alignment and Technology.

Access: Payment models that recognize access, especially in areas where there is a lack of health care providers in primary care or other specialties, will incentivize the use of telemedicine to increase access to these populations.

Specialized Populations: Models focused on reducing the cost of care through the use of lower care settings. This is currently ubiquitous throughout most payment models, including ACOs, bundled payments, patient-centered medical homes.

Payment Alignment and Technology: Any model that includes incentives for providers to lower the cost of care through aligning payment to promote the most efficient use of technology to reach the lowest cost of care setting delivery. This can be achieved through focusing on population specific models such as for the long-term care population and the post-acute care population where transitions among health care facilities and transportation to physician and health care facilities are difficult or expensive.

American Well has a number of innovative installations including:

- BlueCross BlueShield of Louisiana: Blue Cross and Blue Shield of Louisiana leverages American Well's telehealth platform as an added feature of its new Quality Blue Primary Care (QBPC) population health and quality improvement program, and will create multiple avenues to use this technology in other programs.
- BlueCross BlueShield of Massachusetts: Blue Cross Blue Shield of Massachusetts is piloting the American Well Online Care within provider groups in its groundbreaking Alternative Quality Contract (AQC).

3. How has the advancement of telemedicine in recent years benefited the discovery, development, or delivery of healthcare?

Telehealth – real-time, synchronous audio-video encounters between patients and providers – presents the opportunity to reverse the longstanding standard of placing the burden on patients to seek care where it's physically available. Telehealth brings healthcare directly to the patient, when and where they need it – similar to an old-fashioned “house call” – but with the added benefits technology to aid in its delivery.

Telemedicine has been shown to offer numerous benefits, including reducing health care costs, increasing patient access (particularly in underserved areas, off hours, and high wait time regions), improving continuity and quality of care, and increasing convenience—thereby reducing treatment time and related costs of travel and lost productivity. For example, a study by Deloitte predicts that this year alone, there will be

100 million eVisits globally, potentially saving over \$5 billion when compared to the cost of face-to-face doctor visits.

One of the most important benefits of telehealth – particularly through American Well’s technology – is the ability to deliver health care anytime, anywhere, from any location to any other location. This goes a long way to increasing care management and appropriate utilization for currently underserved patients, reducing health care spending by improving long-run patient outcomes. A 2011 study published in *Health Affairs*, “Integrated Telehealth And Care Management Program For Medicare Beneficiaries With Chronic Disease Linked To Savings,” found that integrating a telehealth tool with care management for chronically ill Medicare beneficiaries yielded spending reductions of approximately 7.7 percent to 13.3 percent (\$312–\$542) per person per quarter. By streamlining the delivery of health care, telehealth improves outcomes and can decrease costs.

In addition to improving the delivery of healthcare, telehealth is driving innovation in other areas as well. An article in the *Telemedicine Journal and E-Health* (“Telehealth Innovations in Health Education and Training”) finds that a desire to increase the utilization of telehealth will also likely drive downstream key innovations in technology such as simulation models that can be access from all quality computers, software and hardware interfaces, portable telehealth systems, and other innovative technologies. To that end, American Well has recently developed and deployed a state-of-the-art telehealth kiosk, which can be deployed at numerous locations, including an employer’s worksite, to allow patients to access a licensed, credentialed physician for a live, face-to-face immediate or scheduled visit. We look forward to driving further innovation in this field and constantly improving our technologies.

4. As the capacity for telemedicine continues to grow, what regulatory bottlenecks are most likely to get in the way of its further development?

As outlined in American Well’s testimony for the May 1, 2014 Subcommittee hearing, regulatory barriers play a large role in impeding telemedicine innovation and use in the United States.

Clinical Permissibility and Federal Standards: As innovation in telehealth progresses and states take positive steps to encourage this kind of care, it is increasingly obvious that Federal legislation is required to resolve the uncertainty that has resulted from a confusing patchwork of state and local regulations. Currently there exist 50 different sets of rules governing telehealth across the nation—with varying definitions of what telehealth is and what it is allowed to do. The Subcommittee should consider promoting a uniform solution to this patchwork of state laws and regulations. Thus, we urge the Subcommittee to consider, and report out, the bipartisan *Telehealth Modernization Act* (H.R. 3750), introduced by Representatives Doris Matsui and Bill Johnson, both members of the Energy and Commerce Committee. This legislation provides principles which the states can look to for guidance when developing new policies that govern

telehealth. These principles are based on a “highest common denominator” approach, which will ensure the safe and secure deployment and utilization of telehealth.

Additionally, when contemplating federal legislation in the telehealth space we advise the Subcommittee to consider the *Appropriate Use of Telemedicine in the Practice of Medicine*—a new model national policy ratified by the Federation of State Medical Boards (FSMB) in April. This document is the latest and most comprehensive review of telemedicine clinical practices and marks the first time the medical community has unilaterally acknowledged the impact technology has had on the practice of medicine. In addition to defining telemedicine, the FSMB’s new model policy affirms that: treatment made in an on-line setting should be held to the same standard of appropriate practice as those in traditional settings; a physician-patient relationship can be established using telemedicine, so long as the standard of care is met; prescribing in a telehealth encounter should be at the discretion of the physician; and that telehealth encounters should be HIPAA compliant, include informed consent and the generation of a medical record, and support continuity of care.

Licensure: The existing health professional licensure and practice regulations significantly limit the ability of a health professional to practice via telemedicine, thereby limiting patient access and choice. Currently, health professionals must be licensed in the state in which they provide care, leading those who wish to practice across state lines via telehealth technologies to acquire duplicate licenses and to maintain expertise in separate practice rules in each state. However, through technology, doctors and other healthcare professionals can now be physically located in one state, while their expertise is required in another; in theory, enabling them to provide their expertise, and often life-saving care, to those in need across state lines. Licensure is a lengthy and costly process for providers, and each state has its own rules around standards-of-care and scope-of-practice regulations, particularly where telehealth is concerned.

Lawmakers have introduced in the 113th Congress legislation to expand on the Servicemembers’ Telemedicine & E-Health Portability (STEP) Act, which expanded Department of Defense licensure exemptions to allow for health professionals to practice across state borders. The VETS Act (H.R. 2001) would enable Department of Veterans Affairs’ health professionals to serve any veteran in the U.S. without the need for multiple state licenses. Similarly, the bipartisan TELE-MED Act (H.R. 3077), introduced by Ranking Member Frank Pallone (D-NJ) and Representative Devin Nunes (R-CA), would allow Medicare patients to be cared for by a licensed provider from any state.

Reimbursement: Section 1834(m) of the Social Security Act defines telehealth and how Medicare will reimburse for telehealth services. However, under Section 1834(m) not all telehealth costs are reimbursed—far from it. Medicare, which has to come to set the standard, reimburses for telehealth services only when patients present themselves in a rural area, at an originating site that must be a medical facility—not the patient’s home. Thus, in order to receive care via telehealth, patients still must travel to an originating site to get the care they need. This language is archaic, not taking into account the incredible innovation that has occurred in the health sector through telemedicine and technology.

Furthermore, the rural originating site stipulation contained within Section 1834(m) imposes a powerful downstream effect. The majority of the 46 states which have used the latitude afforded them to create their own telehealth reimbursement policies under Medicaid, have largely mirrored the restrictive Medicare policy. Ideally, Section 1834(m) should be modernized to reflect the changing nature of the health care world. We recognize that this raises concerns about increased utilization and, thus, increased costs. However, the Subcommittee should draw on the insights of the Department of Veterans Affairs—which is a leader in the government’s implementation of telehealth—and several innovative state Medicaid programs (such as Colorado, Kansas, and Washington) as it looks at questions of health outcomes, efficiencies, and cost savings.

5. Can telemedicine raise the quality of service provided to patients? If so, how?

By removing barriers such as provider shortage, distance, mobility, and time constraints, telehealth has the ability to transform health care delivery by improving access to quality care. Further, given telehealth’s ability to transcend distance and time, these technologies can offer high and frequent touch to those high risk patients most in need. In addition to increasing access to quality and specialized care, scientific studies have shown that the use of telemedicine for chronic care monitoring, accessing specialists, and other means have resulted in significantly improved care and improved outcomes. Moreover, telemedicine has shown that there is no difference in the ability of a provider to obtain clinical information, make an accurate and appropriate diagnosis, and develop a treatment and follow up plan when compared to an in-person visit.

For example, according to the Department of Veteran’s Affairs, telehealth solutions have an 87 percent satisfaction rate among health care professionals. More important, individuals using telehealth report favorable experiences and often save time over a traditional health care encounter. For example, in FY2012 the Department of Veterans’ Affairs (VA) provided telehealth care to 497,000 patients from 150 VA Medical Centers and 750 Community Based Outpatient Clinics. Not only did this telehealth program decrease bed days and admissions for patients, it did so in a way which yielded high patient satisfaction and cost savings. For home telehealth, patient satisfaction was 85 percent, and for clinical video telehealth, satisfaction was 93 percent. As policymakers continue to seek means to care, and improve care, for our nation’s veterans, telehealth has been a proven means within the VA of improving outcomes.

6. Can telemedicine lead to more patients receiving care without costly, unnecessary, and time-consuming trips to their doctors? If so, how?

Telehealth’s greatest promise is that of bringing care TO the patient, where and when they need it. This expansion of care delivery to lower cost settings will help drive down costs in terms of unnecessary ER utilization, hospitalizations, general overhead, and hospital overload. Telehealth also supports preventative care for those with chronic

conditions, thus reducing the risk of unnecessary exacerbation of these very costly chronic issues.

On average, each telehealth visit saves \$140. More importantly, telehealth has demonstrated the potential to be a driver of cost savings and has commercially saved \$1.05-\$3.40 per member per month (PMPM) (Mercer, “Online Care for Employers: Cost Savings Analysis,” 2012) and has saved \$6.95 PMPM within Medicare (Milliman, “An Actuarial Analysis of Online Care,” 2011). Expanding the ability of patients to access medical services through telehealth will help continue to drive down costs.

Regrettably, Section 1834(m) of the Social Security Act limits Medicare reimbursement for telehealth services that occur at a rural originating site only, thus failing to capture potential cost savings presented by telehealth. The National Rural Health Association (NRHA) has found that the reimbursement to originating sites in rural areas for telehealth is insufficient to cover the costs of providing these services. According to the NRHA, rural providers do not “receive equitable compensation for their provision of services provided via telehealth” and thus are challenged to maintain the support staff that is required to facilitate telehealth visits. If the originating site is not fairly compensated telehealth services, which themselves can save costs and increase care quality, may not even be offered at these originating sites.

Further, by restricting Medicare reimbursement for telehealth only to rural, clinical sites, the opportunity to fully realize the promise of telehealth is lost. This language, first drafted in 2000, does not take into account the significant patient wait times which currently exist in some of nation’s urban areas, the overuse of emergency rooms after hours, or the evolution in telehealth technologies which allow for a great number of healthcare issues to be resolved safely and effectively from the home or the workplace. Re-examining this antiquated language could result in much greater access, cost-savings, and better healthcare management for some of those most in need across the nation.

7. WellPoint now offers patients 24-hour online access to doctors and nurse practitioners at a fraction of the cost of in-person consultations. How does Medicare compare to private insurance in making use of telemedicine such as WellPoint?

American Well is proud of its partnership with WellPoint on its LiveHealth Online national telehealth initiative. WellPoint is making telehealth encounters an integrated benefit for all of their customers over the next 24 months. Patients pay their standard cost-share to visit with a state-licensed and credentialed physician, specifically trained in providing care via telehealth. Patients can receive care regardless of time or location.

Comparatively, Medicare only offers reimbursement in some circumstances. Under the Section 1834(m) of the Social Security Act, Medicare reimburses for telehealth services only when patients present themselves in a rural, clinical originating site. An originating site is the location of an eligible Medicare beneficiary at the time the service is being

furnished through telehealth. In addition, Medicare beneficiaries are eligible for telehealth services only if they are located in a rural Health Professional Shortage Area (HSPA) or in a county outside of a Metropolitan Statistical Area (MSA).

Also, there are three criteria for determining whether a location is an eligible telehealth originating site. Among these criteria, is a geographic measure which allows for sites located in either a county that is not an MSA or in an area designated as a rural HPSA to be considered an originating site. CMS has always interpreted “rural” to mean a location not located within an MSA, but have also looked to the Office of Rural Health Policy’s (ORHP) designations of Rural Urban Commuting Areas (RUCAs) to determine rural areas within MSAs.

Currently, 21 states and the District of Columbia require that private insurers cover telehealth services the same as they would cover in-person health care. Some of these states have rural restrictions within their mandates, reflecting the language contained within Medicare provisions.

Consistency and modernization of telehealth reimbursement policy is a necessary next step in the further adoption of telemedicine, particularly by physicians and other providers.

- 8. There are fears of a physician shortage in coming years. With doctors showing increasing reluctance to accept new Medicare patients to their practice, could telemedicine help extend the reach of those currently in practice and allow them to expand the number of patients they can see? For example, could virtual visits allow for a physician or other support staff to see some patients sooner with low risk concerns?**

One of the primary benefits of telehealth is expanding access to quality care by extending the reach and availability of providers and decreasing wait times for those seeking care. Given the great advancements in telehealth technologies in recent years, this care can be delivered in an environment as safe and secure as care provided in person.

For example, American Well’s telehealth platform is designed to be HIPAA compliant and secure, allows for providers to view patient medical history, can integrate with diagnostic and medical devices, enabling truly meaningful and informed care, and supports multi-disciplinary collaboration which supports the Patient Centered Medical Home. As the platform supports synchronous audio-video encounters, providers are able to interact with patients, review symptoms, and identify any potential contraindications to treatment suggested, and fully document the care and treatment provided.

Through innovative tools, such as the online waiting room, ePrescribing, and other means, American Well’s telehealth solution, and telemedicine in general, can decrease

wait times, increase provider efficiency, and, thus, increase provider availability, thus maximizing the ability for any individual provider to focus on the provision of care.

In addition, by preventing and slowing the onset of a disease to the point where it becomes chronic, telehealth will, in the long run, decrease heavy utilization of the health care system for highly chronic and persistent conditions—thereby freeing physicians who would otherwise be treating these chronic conditions. For example, in lieu of telehealth, 85 percent of health care users would have to visit a more expensive care setting, such as an urgent care center or an ER (Mercer, “Online Care for Employers: Cost Savings Analysis,” 2012). Of the current telehealth online visits, 23 percent occur on the weekend and 33 percent occur before 9am or after 5pm Monday through Friday.

The tremendous potential for telemedicine and its beneficial impact for physicians is a major reason why organizations like Federation of State Medical Boards and the American Medical Association are modernizing their policy positions on telemedicine.

The Honorable Renee Ellmers

- 1. I would like to continue the discussion on care giving. As a nurse for 20 years, it is a topic I am very familiar with. I would like to share some statistics:**
 - **American Caregivers are predominantly female (66%) and are an average of 48 years old.**
 - **Most care for a relative (86%), most often a parent (36%)**
 - **Family caregivers provide an average of 20 hours of care per week.**
 - **One in seven caregivers provides care, over and above regular parenting, to a child with special needs (14%).**
 - **Care giving lasts an average of 4.6 years.**

Making it easier to get care to those who may have trouble traveling long distances to see a provider will improve outcomes and lives. Patients who have chronic conditions live longer and healthier lives when they have coordinated care and adhere to treatment programs. Today, children, often the daughter, are the caregivers for their parents. They are the vital component of coordinated care. Millions of women, who are caregivers, want to be there for their loved ones, but also need to be at home to take care of their children or do their job.

With the billions of dollars invested in using broadband technologies national networks with high speeds and capacity, today’s state by state licensing of doctors is a barrier that should be removed. Established in the 1800s, it is an antiquated relic and it is time for it to be changed as it is proving to be an impediment to providing quality care for seniors. This is why I am a proud cosponsor of Reps. Nunes and Pallone’s H.R. 3077, the Tele-Med Act. A bill that would allow Medicare doctors

licenses in one state to see a Medicare beneficiary across state lines without a separate license.

Can we not use technology to ensure family members and caregivers are included in discussions with the provider and the patient they are caring for? Would it not improve communications if the caregiver can speak with the patient's doctor directly, with the patient and for the patient, and be kept up-to-date with what the doctor is telling the patient, without having that caregiver fly across the country to attend a short appointment? What barriers are we facing to making this a reality?

Through telehealth, family caregivers can receive expanded access to health care information and services, improves caregiver intervention services, increased means of ensuring adherence to interventions, enhanced training for home caregiving, and reduced costs of specialty services for family caregivers.

Per an 11-year review conducted by researchers at Florida State University, "Telehealth and family caregiving: Developments in research, education, and health care policy," telehealth use in family caregiving generally led to significantly greater gains in target outcomes than control groups. The report also collected qualitative findings of family caregivers who reported telehealth increased their ability to share situations and specific problems with physicians reduced anxiety about their caregiving and helped them learn new skills and techniques.

As discussed in American Well's testimony before the Subcommittee on May 1, 2014, there are three main barriers to making prevalent access to telemedicine for caregivers and for the nation a reality: 1) uniform standards of clinical permissibility; 2) licensure; and 3) reimbursement.

Clinical Permissibility and Federal Standards: As innovation in telehealth progresses and states take positive steps to encourage this kind of care, it is increasingly obvious that Federal legislation is required to resolve the uncertainty that has resulted from a confusing patchwork of state and local regulations. Currently there exist 50 different sets of rules governing telehealth across the nation—with varying definitions of what telehealth is and what it is allowed to do. The Subcommittee should consider promoting a uniform solution to this patchwork of state laws and regulations. Thus, we urge the Subcommittee to consider, and report out, the bipartisan *Telehealth Modernization Act* (H.R. 3750), introduced by Representatives Doris Matsui and Bill Johnson, both members of the Energy and Commerce Committee. This legislation provides principles which the states can look to for guidance when developing new policies that govern telehealth. These principles are based on a "highest common denominator" approach, which will ensure the safe and secure deployment and utilization of telehealth.

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