Testimony to the Subcommittee on Commerce, Manufacturing, and Trade

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Summary

Currently, we have tools and technologies that increasingly can enable anyone anywhere to receive care, participate in research, and benefit from its advances. However, policy barriers, especially antiquated state licensure laws and Medicare policies, limit their adoption and access to care. To enable these technologies, including use of smartphones and objective sensors to measure disease and video conferencing to connect patients to convenient care, the federal government could consider the following:

1. The U.S. Food and Drug Administration could provide affirmative guidance to the life sciences industry encouraging and supporting adoption and incorporation of mobile technologies into clinical trials and into the development and evaluation of novel therapeutics.
2. Congress could pass and the President could sign legislation like the Tele-MED Act, which will enable any Medicare beneficiary in the country to receive care from any Medicare provider in the country.
3. Congress could pass and the President could sign legislation like the Medicare Telehealth Parity Act to expand Medicare's coverage of telehealth. Importantly, coverage alone is not enough. Legislation must incent (through higher reimbursement rates) clinicians to adopt telehealth as a means to increase access to care for all Medicare beneficiaries (not just rural ones). Currently, Medicare provides higher reimbursement to care provided in hospital-based clinics. Rather than subsidizing high cost, institution-based care, Congress should incent potentially lower cost, patient-centered care delivered to where patients (not institutions) are.

Statement

Chairman Burgess, Congresswoman Schakowsky, members of the Commerce, Manufacturing and Trade Subcommittee, today we have the means to enable anyone anywhere to receive care, to participate in research, and to benefit from those advances. Unfortunately, policy barriers limit adoption of these new tools.

I am a neurologist at the University of Rochester Medical Center in Rochester, NY and for the past decade, my colleagues and I have been applying technologies, including smartphones, wearable sensors, and video conferencing , to enhance research and improve care for individuals with Huntington disease and Parkinson disease. Currently clinical trials are plagued by limited participation and insensitive outcome measures. For example, only 3% of individuals with cancer participate in clinical trials, and today we assess whether a new drug works for Parkinson disease with paper diaries and subjective assessments of finger tapping. We can progress faster with better tools, including smartphones.

In March 2015, Apple created ResearchKit, an open-source platform for creating smartphone research applications, and released applications for asthma, breast cancer, cardiovascular disease, diabetes, and Parkinson disease. Within a day, 2000 individuals were participating in the Parkinson disease study. In seven months, over 70,000 individuals from every state had enrolled in a study. In one year, nearly 10,000 Parkinson disease study participants were sharing their data with researchers globally.

Because of their potential, pharmaceutical companies are incorporating smartphones into clinical trials. Such use could help determine whether new therapies are efficacious in smaller, shorter, cheaper studies and accelerate our ability to find treatments for Parkinson disease and other neurological disorders that will affect almost all of us.

In addition to smartphones, we use video conferencing to care for individuals with Parkinson disease. Because of distance and disability, over 40% of Medicare beneficiaries with Parkinson disease do not see a neurologist. Those that do not are more likely to fracture their hip, to be placed in a skilled nursing facility, and to die prematurely. Simple video conferencing like Skype enables clinicians to reach patients in their homes. In a pilot study, these virtual house calls were feasible, provided comparable outcomes to traditional care, and saved patients and caregivers 100 miles of travel and three hours of time. With eighteen centers, including Baylor, Northwestern, University of Kansas, and University of Florida, we are conducting the first national randomized controlled trial of virtual house calls for Parkinson disease. Demand for telehealth is high. Over 11,000 individuals from 80 countries and all 50 states visited the study's website, and nearly 1000 individuals wanted to participate in this 200-person study, which will complete this summer.

Despite the promise and potential of these new technologies, policy barriers, including state licensure laws and Medicare's narrow coverage, limit adoption. In 2015, Medicare spent less than one hundredth of one percent of its budget on telehealth. Currently, Medicare pays neurologists ~$150 to see a patient with Parkinson disease in a hospital-based clinic, $80 for a visit in a community-based clinic, and $0 to see a patient remotely in her home. In essence, Medicare subsidizes institution-based care and disincents patient-centered care.

Fortunately, policy solutions are available. The Tele-Med Act (H.R. 3081) would enable any Medicare provider to care for any Medicare beneficiary. The Act mirrors how physicians in the Veterans' Administration can care for any veteran anywhere in the U.S., and last year the VA provided over two million telehealth visits. The Medicare Telehealth Parity Act (H.R. 2948) would expand Medicare's coverage of telehealth, which today reaches veterans, military personnel, Medicaid beneficiaries, and prisoners but largely excludes 50 million older Americans.

Fifty-one years ago, a Texan signed legislation that guaranteed all older Americans health care coverage. Two generations later, Medicare is showing its age. However, this Committee – led by a Texan – can help ensure that this generation's tools fulfill Medicare's founding vision and extend care to every American senior everywhere.

Thank you very much for your time and service.

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Disclosures

Equity interests

Dr. Dorsey is a member of the medical advisory board for and has stock options in Grand Rounds.

Consulting

Dr. Dorsey has served as a consultant to the National Institute of Neurological Disorders and Stroke, Clintrex, GlaxoSmithKline, MC10, MedAvante, Shire, and UCB.

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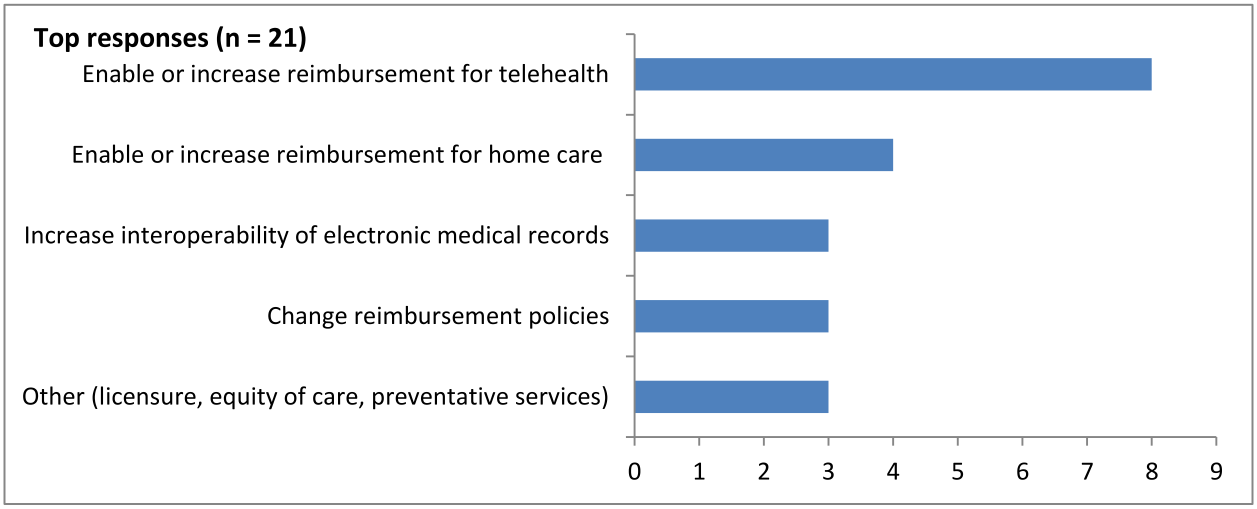
Attachments

My colleagues recently hosted a d.health Summit (www.dhealthsummit.org) on May 4, 2016 in 2016 to foster technology-enabled disruptive care models to enable Americans to age at home. The Summit assembled policy, technology, and health leaders and provided multiple recommendations (**Attachment A**) to enable aging at home, a stated goal of 88% of Americans.

What one policy change would you recommend to the next President that will enable Americans to age at home?



Select Policy Recommendations – d.health Summit 2016

- “Telemedicine reimbursement (by Medicare). I cannot of anything more important. (It is the) most important catalyst by far to bring about home care for individuals with chronic conditions. I cannot think of a close second ... (Medicare's reimbursement of telemedicine) has extraordinary potential for transforming home health care and chronic illness management.”
  - *Senator Tom Daschle, Founder and CEO, The Daschle Group, 2016 d.health Advisory Board*
- “Have CMS provide universal reimbursement for telemedicine.”
  - *Howard Reis, President, The Castleton Group (collaborative focused on connected healthcare)*
- “The most viable recommendation is to allow all participants in Medicare’s various payment innovations to cover telehealth as they find prudent - such as Medicare Advantage, accountable care organizations, bundled payments and the Independence at Home Demonstration.”
  - *Gary Capistrant, Chief Policy Officer, The American Telemedicine Association*
- “Clarify (unrestrain) role of telehealth in home health and hospice agencies.”
  - *Dr. Steven Landers, CEO, VNA Health Group*
- “Require interoperability and data exchange for all health EMRs to facilitate population health management.”
  - *Brooke Hollis, Associate Director, Sloan Program in Health Administration, Cornell University*
- “Make health plans and managed care organizations (and payers) responsible, accountable and exposed to costs for both Medicaid and Medicare.”
  - *Robert Herzog, CEO and Founder, eCaring*
- “Universal medical licensure (vs. state by state). This facilitates efficient care delivery for aging-in-place patients (and their caregivers), and helps maximize the impact of highly specialized physicians."
  - *Owen Tripp, Co-founder and CEO, Grand Rounds*
- “Racial and ethnic disparities in healthcare have been a major public health goal for two decades. Mandatory collection of accurate patient level data on race, ethnicity and language would allow all health care quality indicators to be tracked for equity of care delivered.”
  - *Dr. Lynne Richardson, Professor of Emergency Medicine, Icahn School of Medicine at Mount Sinai*