



## **Enhancing Access to Care at Home in Rural and Underserved Communities**

Statement by  
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Thank you, Chairman Smith, Ranking Member Neal, and distinguished members of the Committee; I am honored to speak to you today on the bipartisan topic of finding solutions to the dramatic access challenges affecting patients and families living in rural and underserved communities.

My name is Chris Altchek. I am the founder and chief executive officer of Cadence. Our expertise is in the better management of chronic disease through remote physiologic monitoring (RPM) and medication optimization, which our data show improves health outcomes while lowering the cost to the federal government of caring for Medicare beneficiaries. We provide these services to over 18,000 patients living with heart failure, hypertension and type 2 diabetes nationwide, nearly 12,000 of whom live in rural or underserved communities. In partnership with some of the most innovative health systems in the country, Cadence offers chronic disease management tools and services that give patients – including those in remote areas – 24/7 access to our care team through cutting-edge technology.

### **Introduction**

RPM, as defined by the Centers for Medicare and Medicaid Services (CMS), involves the collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.<sup>1</sup> The availability of reimbursement for these services enables a team-based approach to care furnished via audio-only communication technology, which is critical for the patient population at the center of today's hearing.

I am pleased to be here discussing a strongly bipartisan priority. CMS Administrator Seema Verma led the creation of RPM services in Medicare under the leadership of President Trump. The Biden administration has been a strong champion for this care, with CMS expanding access to patients being served by rural health clinics and federally qualified health centers. CMS recently outlined plans for clinicians to use RPM to support mothers participating in the Innovation Center's upcoming Transforming Maternal Health model through remote monitoring of conditions like hypertension and diabetes.<sup>2</sup>

This being said, more can be done to enhance the availability of care management tools like RPM in rural and underserved communities that face limited access to primary care.<sup>3</sup> Cadence is at the forefront of providing digitally enabled care management services to these individuals, as a majority of our patients live in rural and underserved areas. Adopting RPM allows clinicians to maintain closer contact with patients through the improved management of chronic conditions. With the clinical team at Cadence supporting them, primary care doctors are able to increase access to care for patients in areas suffering from clinician shortages and limited transportation options.

My testimony will focus on challenges to the adoption and scaling of technology empowering older Americans in rural and underserved communities. I recommend:

1. Addressing geographic adjustments in Medicare payment that prevent patients in rural and underserved areas from being able to access RPM for their chronic conditions. Reimbursement for RPM must cover the cost of providing these services, and currently does not meet that threshold in many rural and underserved areas.
2. Working with CMS to support an appropriate national average reimbursement rate to ensure continued patient access to high-value, evidence-driven RPM services.
3. Removal of beneficiary copays for highly effective RPM services that are demonstrating savings for the Medicare program. These services are leading to Medicare savings in the form of reduced hospital readmissions and we must remove barriers preventing access by poorer patients.

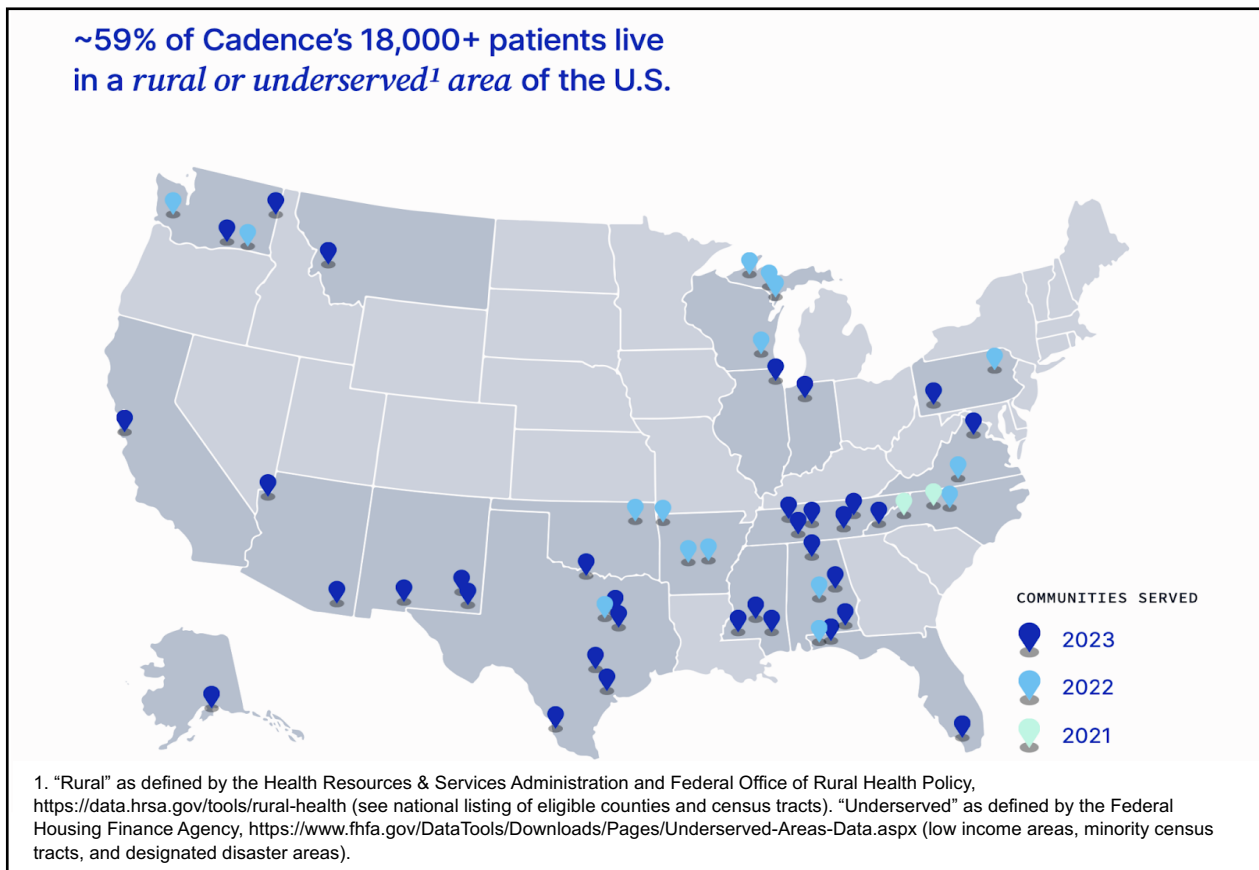
### **Cadence's Role in Ensuring Access to RPM Services**

How does Cadence's RPM program work? A Cadence patient is on average 74 years old and is frequently hospitalized. After their local physician orders Cadence remote monitoring, the patient receives an easy-to-use, cellular-enabled device(s). There is no need for broadband, Wi-Fi, or a smartphone. They are connected and transmitting vitals seamlessly, with 24/7 support. The Cadence clinical team uses vitals data (e.g., blood pressure, heart rate, weight, blood glucose level) and the electronic medical record to adjust medications, order labs, and get patients onto the optimal care plan quickly and safely. Critically, patients can call or text anytime and get in touch with a care team member who has visibility into their vitals and medical record. Data show that Cadence remote monitoring helps patients achieve better clinical outcomes (100% increase in patients achieving goal blood pressure), avoid emergency room visits (50% decrease), and lightens the load on already overburdened primary care providers in rural and underserved areas.

Before Cadence, when seniors have challenges, they call their primary care provider and may struggle to quickly get an appointment, often ending up in the emergency department as a result. With Cadence, patients receive proactive calls when vitals present a concerning trend. Cadence clinicians work quickly to assess symptoms, make changes to medications remotely when possible, and get these patients in-person care in the appropriate setting. We make patients' health care experience dramatically better, and allow clinicians to work more efficiently.

One of our patients recently said it best: “I live in a tiny, remote, mountain community with a lot of poverty and not a single doctor. Everyone that I’ve told about Cadence is amazed by it. I’m very pleased, and I think my clinical team is tremendous.”



In less than two years, Cadence has deployed in 20 U.S. states and is augmenting existing primary care relationships for thousands of seniors suffering from heart failure, hypertension, and type 2 diabetes. Patients say they feel safer and more connected to their providers, with 84 percent of Cadence patients reporting their vitals at least 16 days per month. The adoption of RPM is also freeing up clinicians to see more patients through the reduction of unnecessary visits, increasing access to care in communities suffering from shortages of clinical staff.



### **RPM Enables Highly Coordinated Primary Care**

Cadence’s experience treating and managing thousands of Medicare beneficiaries alongside primary care providers has made clear that RPM is key to the future of primary care. Ninety-five percent of the physicians who order our RPM services are primary care providers who want to improve how they manage their patients’ chronic conditions outside of the office visit. Patients in the Cadence program are highly engaged and report vitals daily, leading to a 23% decrease in patients’ total cost of care, inclusive of the incremental costs associated with RPM services. The program also results in significant improvements in quality of care: Our data show a 230% increase in the percentage of congestive heart failure patients on all four pillars of Guideline

Directed Medical Therapy, the “cornerstone of pharmacological therapy for patients with heart failure.”<sup>4</sup>

	Better clinical outcomes		Lower cost of care
IMPACT	WHY IT MATTERS	IMPACT	
<b>230%</b>	Increase in patients achieving all four pillars of Guideline Directed Medical Therapy (GDMT) <sup>1</sup>	For a 70-year-old <u>heart failure patient</u> , achieving GDMT provides an additional 5.2 years on average <sup>2</sup>	<b>63%</b>
<b>100%</b>	Increase in patients with well-controlled blood pressure <sup>4</sup>	For every 20 mmHg systolic or 10 mmHg diastolic decrease in blood pressure, risk of both <u>heart disease</u> and <u>stroke</u> decreases 50% <sup>5</sup>	<b>50%</b>
<b>43%</b>	Of <u>diabetic patients</u> achieved goal (A1C < 7) <sup>6</sup>	Every 1 point decrease in A1c significantly decreases the risk of <u>diabetes-related fatality</u> <sup>7</sup> , and <u>heart attack</u>	<b>23%</b>
<small>1. Feldman, D. I., Campbell, M. L., Feldman, T., Curnow, R., &amp; Fudim, M. (2023). Breaking the Status Quo in Heart Failure: Leveraging Remote Patient Monitoring to Effectively Put the Heart Failure Guidelines to Practice; 2. Fonarow GC, et al. Am Heart J 2011; 161:1024-1030 and Lancet 2008. 372 1195-1196; 3. Results based on a difference-in-differences analysis using ACO data using patients enrolled in Cadence in 2022 inclusive of over 9,000 eligible patients with congestive heart failure, hypertension or type 2 diabetes. 4. A Nationwide Remote Patient Intervention Hypertension Program: Can Remote Patient Monitoring And A Multi-Control?; David I. Feldman, MD, MPH; 2023 Nov; Well controlled defined as less than 130/80 mmHg; 5. National High Blood Pressure Education Program. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. Bethesda (MD): National Heart, Lung, and Blood Institute (US); 2004 Aug. Blood Pressure and Cardiovascular Risk; 6. Data under review pending formal publication; 7. Stratton et al, 2000: Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. BMJ; 8. Calculated as average reduction in total cost of care between patients enrolled in Cadence versus eligible but never enrolled. Based on ACO data using patients enrolled in Cadence in 2022 inclusive of over 9,000 eligible patients with congestive heart failure, hypertension or type 2 diabetes.</small>			

Our approach at Cadence has several distinctive features that directly support an integrated approach to primary care. Specifically, we have a nurse practitioner-led clinical team, a technology platform that is fully integrated with the ordering provider’s electronic health record, and 24/7 support available to patients. We refer to this as “high quality RPM,” in that it allows for a team-based, coordinated approach to a patient’s physiologic data, safe and responsive titration of medications, and timely escalation to the appropriate care setting. These features have led to the significant positive clinical and cost-saving results in our data. Through this hands-on, tightly coordinated approach, Cadence ensures that primary care providers are able to identify and prioritize those patients who need their attention the most.

## Current Literature on RPM

RPM has generated robust data in support of improved clinical outcomes for patients with chronic conditions. A randomized, controlled trial demonstrated that an RPM intervention could lead to optimization of vitals and increase in the use and dose of medical therapy for patients with heart failure, which is an accepted surrogate for hard clinical outcomes including heart failure hospitalization, morbidity, and mortality.<sup>5</sup> This was validated in a 2018 randomized controlled trial that studied the effect of an RPM intervention in heart failure patients and demonstrated a reduction in the percentage of days lost due to unplanned cardiovascular hospital admissions and all-cause mortality.<sup>6</sup> Remote monitoring and care also improves blood pressure<sup>7</sup> and blood glucose<sup>8</sup> control in hypertension and type 2 diabetes patients, respectively.

## Current Medicare Payment Limits Rural Patient Access to RPM

Rural patients generally have less access to in-person primary care services than their non-rural counterparts. It is particularly important to enable RPM services for these communities. Patients on Cadence’s RPM program experience meaningful clinical improvements, such as well-controlled blood pressure and achieving blood glucose goals. We encourage the Committee to prioritize policies that permit the growth of high-value, evidence-driven RPM programs.

Currently, there is a geographic variation in reimbursement for RPM, which disincentivizes the adoption of these services in rural areas where payment is generally lower. While costs for in-person care are primarily related to workforce costs and often vary geographically, the costs of furnishing some digital health services like RPM tend to be independent of the service location. Cadence uses the same model of care and clinical workforce regardless of where patients live. Identical high quality services including providing medical devices, educating the patient on the devices, monitoring physiologic data on an ongoing basis, and delivering treatment management services are reimbursed at different rates under the CMS formula. For example, RPM reimbursement in rural Missouri is 33% of what it is in San Francisco, California and 11% below the national average, even though the costs associated with this service are largely the same.

CMS’ own data shows that RPM reimbursement is lower in areas where the prevalence of heart failure (HF), hypertension (HTN), and diabetes is higher:

<b><u>RPM reimbursement is 33% less in rural Missouri versus San Francisco, despite higher chronic disease prevalence in rural Missouri</u></b>						
	Prevalence of Chronic Disease <sup>1</sup>			RPM Reimbursement <sup>2</sup>		Monthly Per Patient Reimbursement
	HF	HTN	Diabetes	99454	99457	<i>Ex. Claim with single units of 99454, and 99457 (i.e., one month of RPM services)</i>
<b>San Francisco Cty, CA</b>	10%	51%	26%	\$65.66	\$60.24	\$126.08
<b>Rural Missouri<sup>3</sup></b>	15% <b>(+5%)</b>	57% <b>(+6%)</b>	27% <b>(+1%)</b>	\$39.98	\$44.31	\$84.29 <b>(-33%)</b>

1. CMS Chronic Conditions Public Use Database, "Chronic Conditions Prevalence, State/County 2018," <https://cms-oeda.maps.arcgis.com/apps/MapSeries/index.html?appid=062934f815eb412182b3d324054ea6f0>

2. Reimbursement represents Payment Amounts per the 2024 CMS Physician Fee Schedule in Place of Service 11 (Non-facility)

3. Reimbursement represents the "Missouri - Rest of State" MAC locality, which excludes counties in urban St. Louis (JEFFERSON, ST. CHARLES, ST. LOUIS AND ST. LOUIS CITY) and Kansas City (CLAY, JACKSON AND PLATTE)

Unfortunately, current RPM reimbursement is inadequate in many rural and exurban areas relative to the resources required to create and maintain an effective program that conforms to CMS' requirements. High quality RPM is labor-intensive and requires technical expertise. Costs associated with devices and our technology platform include:

- Cellular and Wi-Fi-enabled medical devices. We source and program each device to upload patient readings automatically to the Cadence platform. Additional costs associated with devices include shipping fees; ongoing cellular fees per device; in certain instances, cellular or Wi-Fi signal boosters to enable connectivity and avoid data collection disruptions for patients located in rural areas with poor cellular or internet connections; and replacement parts or devices.
- Continuous patient support. We staff care team members 24 hours a day, 7 days a week, and 365 days a year to address patient and device issues. Labor-intensive and costly around-the-clock service is necessary to ensure timely care for patients with chronic and acute conditions and avoid unnecessary trips to the emergency room. Patients have access to Cadence 24/7 via text message, phone, and email.
- Technology platform and data security. We sync patient vitals from our software to the electronic medical record to ensure this information is captured in the patient's chart. We also staff a team to improve electronic medical record integrations, which are far from standardized in the United States today, and employ full-time software engineers who design and engineer improvements, address software issues, and ensure the security of patient information.

We believe the Committee should consider legislation that implements an adjustment in Medicare by setting a floor for payment related to RPM. A logical approach to determining this floor would be to benchmark it to the average payment rate for all geographies, without the rural payment adjustment included.

### **Cuts to the National Average Payments Threaten to Curtail Patient Access**

Moreover, national average Medicare reimbursement (non-facility) for monthly recurring RPM services has dropped so substantially since 2019 that it is increasingly challenging to cover the costs of providing effective RPM services to patients. As illustrated in the table below, cuts to these CPT codes range from 7 percent up to a staggering 28 percent, despite the increasing costs of devices and labor required to deliver RPM. Such significant decreases in a short period of time suggest a bleak outlook for patient access to these demonstrably high-value services.

	CPT Code Reimbursement <sup>1</sup>		Monthly Per Patient Reimbursement
	99454	99457	<i>Ex. Claim with single units of 99454, and 99457 (i.e., one month of RPM services)</i>
<b>2019</b>	\$64.15	\$51.54	<b>\$115.69</b>
<b>2024<sup>2</sup></b>	\$46.50	\$48.13	<b>\$94.63</b>
<b>% Change</b>	<b>-28%</b>	<b>-7%</b>	<b>-18%</b>

1. Reimbursement represents the "National Payment Rate" per the 2024 CMS Physician Fee Schedule in Place of Service 11 (Non-facility)  
2. 2024 Reimbursement is accurate as of 3/1/24, prior to the impact of the Consolidated Appropriations Act, 2024 (H.R. 4366)

The Committee should take steps to ensure that Medicare appropriately reimburses the clinical team’s work involved in maintaining longitudinal relationships, providing personalized care, and coordinating across the care team via RPM. These are high-impact services for both patient outcomes and costs that should be valued accordingly.

Beyond Medicare, reimbursement for RPM services by Medicaid and commercial payors is uneven. The lack of alignment across Medicare, Medicaid, and commercial plans regarding coverage of RPM services makes it difficult for physicians to reliably provide these services and for patients to know what services are accessible to them. While a majority of state Medicaid programs cover some form of remote monitoring services, many do not cover all of the RPM codes and reimbursement is often significantly lower than Medicare’s rates.<sup>9</sup> Commercial coverage can also entail restrictions that are not present under Medicare, such as only covering RPM for particular disease states, even if the clinical efficacy of RPM is proven for other conditions.

As we can generally expect to see private payors follow Medicare’s lead, I encourage Congress to take action to halt the precipitous declines in reimbursement for RPM services we have experienced over the past five years.

**Removal of Copays on RPM Services**

I also support existing Congressional efforts to eliminate the 20 percent copay for RPM services for at least a two-year period in order to study the effects on patient outcomes and cost savings to Medicare.<sup>10</sup> The financial burden of the copay obligation is a top reason patients disenroll from Cadence’s RPM program, even as these patients are seeing improvements to their health and appreciate the support of a 24/7 remote care team. Such legislation would be an important step toward improving health outcomes in rural and underserved communities, in addition to reducing travel times for rural patients and lessening the burden on health care providers.

## **Conclusion**

In closing, RPM plays a critical role in providing older Americans in rural and underserved communities with access to world-class care for chronic disease. I appreciate the Committee's dedication to enhancing health care access for this patient population. I thank Chairman Smith, Ranking Member Neal, and members of the Committee for allowing me to appear before you today to discuss this critical topic in health care.



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- <sup>1</sup> 85 FR 84472, at 84542 (Dec. 28, 2020), <https://www.federalregister.gov/d/2020-26815>.
- <sup>2</sup> CMS, Transforming Maternal Health Model, <https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model> (accessed Mar. 2024).
- <sup>3</sup> Petterson, S. M., et al., Unequal distribution of the US primary care workforce. *American family physician*, 87(11) (2013), <https://pubmed.ncbi.nlm.nih.gov/23939507/>.
- <sup>4</sup> Patel J., et. al., Guideline-Directed Medical Therapy for the Treatment of Heart Failure with Reduced Ejection Fraction (2023), <https://pubmed.ncbi.nlm.nih.gov/37254024/>.
- <sup>5</sup> Desai A. S., et al., Remote Optimization of Guideline-Directed Medical Therapy in Patients With Heart Failure With Reduced Ejection Fraction. *JAMA Cardiol.* 2020 Dec. 1;5(12):1430-1434. DOI: 10.1001/jamacardio.2020.3757.
- <sup>6</sup> Koehler F., et al., Efficacy of telemedical interventional management in patients with heart failure (TIM-HF2): a randomised, controlled, parallel-group, unmasked trial. *Lancet.* 2018 Sept. 22;392(10152):1047-1057. DOI: 10.1016/S0140-6736(18)31880-4.
- <sup>7</sup> Blood A. J., et al., Results of a Remotely Delivered Hypertension and Lipid Program in More Than 10 000 Patients Across a Diverse Health Care Network. *JAMA Cardiol.* 2023 Jan. 1;8(1):12-21. DOI: 10.1001/jamacardio.2022.4018.
- <sup>8</sup> Lee P. A., et al., The impact of telehealth remote patient monitoring on glycemic control in type 2 diabetes: a systematic review and meta-analysis of systematic reviews of randomised controlled trials. *BMC Health Serv Res.* 2018 Jun. 26;18(1):495. DOI: 10.1186/s12913-018-3274-8.
- <sup>9</sup> Center for Connected Health Policy, Remote Patient Monitoring (accessed Mar. 2024), <https://www.cchpca.org/topic/remote-patient-monitoring/>.
- <sup>10</sup> See RPM Cost Sharing Elimination Study Act of 2023, <https://cherfilus-mccormick.house.gov/sites/evo-subsites/cherfilus-mccormick.house.gov/files/evo-media-document/rpm-bill.pdf>.