Congress of the United States
Washington, DC 20515

March 15, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Slavitt:

We write as Members of the bipartisan House Energy & Commerce Committee Telehealth Working Group to encourage the Centers for Medicare and Medicaid Services (CMS) to incorporate telemedicine in its implementation of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which passed into law in April 2015.

We are encouraged by CMS' recent work to expand access to telemedicine services by waiving Social Security Act §1834(m) geographic and originating site restrictions for the Next Generation Accountable Care Organizations (ACOs) and by the President's fiscal year 2017 budget proposal to expand the ability of Medicare Advantage plans to deliver services via telehealth and enable rural health clinics and federally qualified health centers to qualify as originating telehealth sites under Medicare.

We believe that telemedicine has the potential to truly achieve the "triple aim" in health care – better care, improved outcomes, and reduced costs. The promise of telemedicine also fits perfectly into the Department of Health and Human Services' delivery system reform strategy, centered on the three key ideas of paying for quality over quantity, improving care delivery and creating better access to health care information.

First, telemedicine is a natural fit within innovative alternative payment models that focus on patient-centered care, care coordination and integration, and population health management. The role of telemedicine in improving outcomes and reducing costs is even more straightforward in models that include risk-sharing, and providers should not face policy obstacles when willing to take on shared financial risk for the anticipated benefit of telemedicine.

Telemedicine also embraces care delivery improvement by addressing long-standing barriers to healthcare access for people in both rural and urban settings. Using technology to deliver care can improve access to providers; yield savings in terms of distance traveled, lost work time and transportation costs for in-person physician visits; and reduce unnecessary trips to an emergency room.

And finally, telemedicine supports CMS' goal of increasing access to information and engaging patients in their own care. The use of technology to remotely track a patient's own health as well as connect with their provider supports consumer and clinician decision making through better information.

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There is substantial and growing evidence of the value and effectiveness of telemedicine services in the private and public sectors, with successful implementation in private plans, Medicare Advantage (MA) populations, the Veterans Administration (VA), and state Medicaid programs. We would encourage CMS to look to existing data within MA, the VA, and Medicaid for evidence of success.

Specifically, within the MACRA constructs of MIPS and APMs, there are multiple opportunities to incorporate telemedicine that should not be missed.

Under MIPS, Medicare Part B providers will be evaluated based on quality, resource use, clinical practice improvement activities, and meaningful use of certified Electronic Health Record (EHR) technology. The use of telemedicine technologies such as remote synchronous face-to-face video visits between providers and patients or remote patient monitoring of chronic conditions should be specifically outlined as a clinical practice improvement activity. The incorporation of telemedicine data should also be considered a meaningful use of an EHR.

Secondly, MACRA incentivizes participation in alternative payment models (APMs) that meet high standards. Eligible APMs under MACRA, which are required to bear more than nominal financial risk, should not be subject to §1834(m) telehealth restrictions. Telemedicine should be specifically acknowledged and defined as a tool for eligible APMs to meet high standards of care. For example, telemedicine could be explicitly identified within the Patient-Centered Medical Home model.

Connecting patients to care in a more convenient and timely manner, and coordinating that care across providers using technology and electronic health records *will* reduce duplicative services and tests, and *will* help avoid preventable emergency room visits and re-hospitalizations. Telemedicine truly has the potential to help us reach the goal of "better care, smarter spending, and healthier people." We hope that CMS can build on recent efforts within the Medicare program and seize on this immediate opportunity to advance telemedicine with the aim of spending health care dollars more wisely and improving individual and community health.

Thank you for your consideration as you work to implement MIPS and APMs under MACRA. We look forward to a robust continued dialogue on the ways in which telemedicine can and will be incorporated into this endeavor.

Sincerely,

GREG WALDEN
Member of Congress

DORIS MATSUI
Member of Congress

PETER WELCH
Member of Congress

ROBERT LATTA
Member of Congress

GREGG HARPER
Member of Congress

BILL JOHNSON
Member of Congress

MARKWAYNE MULLIN
Member of Congress