

REPORT TO CONGRESS

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E-health and Telemedicine

U.S. Department of Health and Human Services

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I. CURRENT CONTEXT AND CONGRESSIONAL REQUEST

I.A. Introduction

Congressional Request

This report responds to the Congressional request, as part of an appropriations bill signed into law in December 18, 2015 (P.L. 114-113), for the Department of Health and Human Services' (HHS) to provide an update on our current telehealth efforts.

“The Committee urges the Department to increase collaboration and coordination across relevant Federal agencies on E-health and telemedicine to assess current efforts, needs, barriers, standards, goals, eliminate duplication and incompatibility, and ultimately improve health quality, effectiveness, and outcomes. The Department shall provide a report within 180 days after enactment of this act to the Committees on Appropriations of the House of Representatives and the Senate with its analysis, including any recommendations on improving the existing E-health and telemedicine efforts.”¹

In this report, we address Congressional interest in federal telehealth policy and coordination. While this report discusses various aspects of telehealth activities and challenges that apply in some cases to both federal government programs and the private sector, we focus the report primarily on activity occurring within HHS and discuss how delivery system reform initiatives may increase the use of telehealth. We close with a budget proposal related to telehealth in the Department's FY 2017 budget request.

Delivery System Reform

Accelerated by passage of the Affordable Care Act (ACA), health care delivery in the United States has been undergoing rapid and significant transformation. In addition to expanding coverage to millions of previously uninsured individuals, the ACA ushered in a new era of delivery system reform (DSR) driven by payment models that emphasize value over volume and encourage greater coordination across the care continuum. Value-based purchasing programs and alternative payment models, such as Accountable Care Organizations (ACOs) and bundled payments, are being implemented both by publicly financed health insurance programs and in the private insurance market. Underlying these models are various innovations, with the simultaneous goals of improving efficiency and quality of care.

As alternative payment models incorporate greater levels of accountability for spending, this may facilitate additional expansion of telehealth. For example, a new payment model, the Next Generation ACO Demonstration incorporates a telehealth expansion waiver that eliminates both the Medicare fee-for-service program's originating site requirement and rural Health Professional Shortage Area requirement. The waiver allows beneficiaries aligned with these ACOs to receive telehealth services in their home, regardless of whether they live in a rural area.² Evaluations of models such as the Next Generation ACO Demonstration may provide evidence on how telehealth can be used to further the goals of DSR. The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) enacted last year includes telehealth provisions, which are discussed later in this report.

Importance of Telehealth Services

In general, telehealth holds promise as a means of increasing access to care and improving health outcomes. Some analysts also see the potential for telehealth to reduce costs.³ Telehealth has existed in some form for decades. For instance, radiologists and dermatologists have relied on store-and-forward techniques, for instance transmission of videos or digital imagery (e.g., X-rays) through a secure electronic communications system since the 1980s.⁴ However, significant advances in telecommunications, including the improvement of high resolution imaging and greater access to broadband, have accelerated the use and availability of telehealth by a broad array of physicians and clinicians. For instance, it is estimated that sixty-one percent of health care institutions currently use some form of telehealth⁵, and between 40 and 50 percent of all hospitals in the United States currently employ some form of telehealth.⁶ This figure includes rural/critical access hospitals, academic medical centers, and urban institutions. In 2013, the market for telehealth generated annual revenue of \$9.6 billion, a 60 percent growth from 2012.⁷ Moreover, the ubiquity of internet-linked mobile computers, such as iPads, and video platforms, such as Skype, enable “direct” consultations between providers and patients located hundreds of miles apart.

The availability of telehealth is of particular interest for patients who live in areas that are inadequately served.⁸ Access to certain medical specialties, such as oncologists, is limited in rural areas.^{9,10} Currently, 59 million Americans reside in Health Professional Shortage Areas (HPSAs), rural and urban areas with shortages of primary care providers.¹¹ Of special concern are rural individuals who have higher mortality rates; a greater chance of being unnecessarily hospitalized; and have one-third as many specialists per capita as do persons living in cities.¹²

Telehealth appears to hold particular promise for chronic disease management. Almost 50 percent of all adults in the United States have at least one chronic illness. Chronic disease accounts for approximately 75 percent of all health care expenditures and contributes to about 70 percent of all deaths in this country.¹³ Many persons with chronic conditions are elderly, and therefore have mobility limitations. Moreover, people with multiple chronic conditions typically require frequent visits to clinicians. Ensuring ready access to care for such individuals may help avert costly emergency room visits or hospital stays.¹⁴ However, aside from care for mental health, the majority of telehealth provided for chronic conditions to date has been limited to asynchronous monitoring.¹⁵

In the sections that follow, the report will:

- (1) describe our interpretation of e-health and telemedicine, including the various types of technologies that apply,
- (2) discuss current telehealth policy challenges,
- (3) review current federal telehealth activity, and
- (4) describe a current legislative proposal from the Department

II. BACKGROUND ON E-HEALTH AND TELEMEDICINE

Although the terms “telemedicine” and “telehealth” are often used to describe similar types of technologies, the term “telemedicine” has historically been used to refer specifically to bilateral, interactive health communications with clinicians on both “ends” of the exchange (e.g., videoconferenced Grand Rounds, x-rays transmitted between radiologists or consultations where a remote practitioner presents a patient to a specialist). Whereas, the term “telehealth” incorporates not only technologies that fall under “telemedicine,” but also direct, electronic patient-to-provider interactions and the use of medical devices (e.g., smartphone applications (“apps”), activity trackers, automated reminders, blood glucose monitors, etc.) to collect and transmit health information, often with the intent to monitor or manage chronic conditions.¹⁶ Currently, there are four basic modalities, or methods, of telehealth:

- **Live video (synchronous):** Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. While these videoconferences had historically and exclusively been provider-to-provider telemedicine encounters, many companies such as Teladoc and LiveHealth Online are now videolinking patients directly to clinicians on a daily basis.
- **Store-and-forward (SFT):** Transmission of videos and digital images such as x-rays and photos through a secure electronic communications system. As compared to a “real-time” visit, this service provides access to data after it has been collected. Generally, diagnostic information (e.g., x-rays, CT scans, EEG printouts) are recorded or captured at the patient’s site of care, and then sent to a specialist in another location. Because of the lag, or delay, between the time an image is sent and when it is interpreted, SFT is often referred to as “asynchronous.”¹⁷
- **Remote patient monitoring (RPM):** Personal health and medical data collection from an individual in one location, which is transmitted to a provider in a different location. RPM is used primarily for the management of chronic illness, using devices such as Holter monitors to transmit information including vital statistics (e.g., blood pressure, blood oxygen levels) to clinicians.
- **Mobile health (mHealth):** Smartphone apps designed to foster health and well-being. These apps range from programs which send targeted text messages aimed at encouraging healthy behaviors to alerts about disease outbreaks to programs or apps that help patients with reminders to adhere to specific care regimens. Increasingly, smartphones may use cameras, microphones, or other sensors or transducers to capture vital signs for input to apps and bridging into RPM.

The term “e-health” is generally used to describe an even broader array of digital information tools, ranging from electronic health records (EHRs), which facilitate the exchange of patient data between health care professionals. E-health may include computerized physician order entry mechanisms, e-prescribing, and clinical decision support tools, which provide information electronically to providers about protocols and standards for use in diagnosing and treating patients.

III. CURRENT POLICY CHALLENGES

At a recent meeting sponsored by the Office of the National Coordinator (ONC) in April 2016, industry executives, medical professionals, and government officials gathered to discuss the opportunities for telehealth in an era of delivery system reform and to prioritize steps that should be taken to facilitate the deployment and use of telehealth modalities. There was broad agreement among participants that payment reform was critical, especially more comprehensive coverage by Medicare; that state licensure barriers continue to temper enthusiasm about telehealth among health care providers; and that high-speed broadband connections still do not reach many rural hospitals and clinics, despite significant growth in fiber-optic infrastructure nationally. These issues, along with privileging and credentialing, are key telehealth policy challenges discussed in this section.

III.A. Reimbursement

The payment environment for telehealth services is evolving across the public and private sector with a considerable amount of variability from one payer to another.¹⁸ Coverage of telehealth services has been uneven across payers due in part to uncertainty regarding the value of telehealth and program integrity concerns regarding duplication of services.

In the case of the Medicare fee-for-service program, as established by Congress in the Balanced Budget Act of 1997, payment goes primarily to the consulting physician or practitioner (at the distant site) with a small facility fee, currently approximately \$25 (or less depending on the actual charge for the telehealth service) paid to the originating site (where the patient is), and requires a live interactive video link between the provider and the patient.^a However, Medicare also pays for “store-and-forward” services (e.g., sending a digital image for later clinical review) through Federal demonstration programs in Alaska and Hawaii, and these services do not require a live interaction between a clinician and patient. The amount of reimbursement for telehealth services in the fee-for-service program has been relatively small. Medicare spent approximately \$14.4 million on services delivered via telehealth in 2015, or less than 0.01 percent of total spending on healthcare services.

In Medicare Advantage (MA), plans are required to provide Medicare-covered telehealth services. Organizations are permitted to offer telehealth coverage that goes beyond the defined Medicare benefit package as supplemental benefits. CMS identified three CY 2016 health care delivery systems (Kaiser, Spectrum and Ministry) with 72 plans that specifically mention covering telehealth for services and/or areas not covered by Medicare’s current telehealth definition. In 2016, two of the largest insurers, Anthem and Humana, are offering remote access technology services to Medicare Advantage enrollees across multiple states,¹⁹ but data on actual MA utilization of any telehealth service is not uniformly collected.

In terms of delivery system reform, as mentioned above, the Centers for Medicare & Medicaid Services (CMS) is currently testing more expansive coverage for telehealth via the Center for Medicare and Medicaid Innovation’s Next Generation ACO Demonstration. Current Medicare payment regulations limit the use of telehealth services to rural Health Professional Shortage Areas (HPSAs) and require the patient to be located in outpatient offices/clinics, hospitals, Federally

^a Under Medicare rules, only the following facilities are eligible to be an originating site: the office of a physician or practitioner; a hospital, including a critical access hospital; a rural health clinic; a federally qualified health center; a skilled nursing facility; a hospital-based dialysis center; a community mental health center. Moreover, originating sites must be located outside of a Metropolitan Statistical Area (MSA).

Qualified Health Centers, or Skilled Nursing Facilities. However, the Next Generation ACO telehealth waiver eliminates both of these preconditions and allows Next Generation ACO beneficiaries to receive telehealth services in their home regardless of whether they are in a rural area. The MACRA legislation enacted in 2015 includes several telehealth provisions. One of the provisions identifies “the use of remote monitoring or telehealth” as an example of an activity that would fall under a care coordination subcategory of the Clinical Practice Improvement Activities performance category under the Merit-Based Incentive Payment System, a new program for assessing physicians’ and other practitioners’ performance and adjusting payments.^b In essence, the MACRA provision offers a possible “reward” to physicians and other practitioners who coordinate care using telehealth modalities, even when direct reimbursement for such activity may not be available. Another provision gives CMS the authority to reimburse providers participating in Advanced Alternative Payment Models for telehealth services. Currently, the Medicare fee-for-service program only reimburses for telehealth, which it requires to be delivered by a videolink and when the patient is at a certified health care facility in a Health Professional Shortage Area. Under MACRA, however, eligible providers participating in a qualifying Alternative Payment Model will have the capacity to provide a broad array of services at a distance using many different telehealth modalities irrespective of where the patient or the clinician is physically located.

Reimbursement for telehealth by Medicaid and private insurers varies greatly, as do the types of clinical services covered. Currently, 48 state Medicaid programs provide some level of telehealth coverage.²⁰ Twenty-two percent of large employers in 2014 covered telemedicine consultations and over 68 percent plan to do so by 2017.²¹ Several Federal Employee Health Benefit Plan insurers offered telehealth services in 2016, and The Office of Personnel Management encouraged all plans to consider telehealth services for 2017.²² Thirty-two states have telehealth parity laws, which require private insurers to reimburse telehealth services at the same rate as in-person consultations. Telehealth is often used by states to support health broadly across the care continuum, including health services that support home video visits and remote patient monitoring. CMS recently promulgated a Final Rule (42 CFR 440, CMS 2348-F), which authorizes the use of telehealth modalities to provide Medicaid home health services^c. After July 1, 2016, for instance, “face-to-face” home health encounters may be delivered using video-calling/-conferencing apps such as Skype™ or FaceTime® or Google Hangouts™. In the past, these services needed to be delivered in person with a provider physically visiting a beneficiary’s residence.

III.B. LICENSURE

Each state has independent authority to regulate and oversee the practice of medicine within its boundaries. These state licensure requirements may be inhibiting broader use of telehealth, with as many as 4 out of 5 states requiring out-of-state clinicians providing telehealth services to be licensed in the state where the patient resides.²³ Although it is not uncommon in places like Philadelphia for providers to have licenses in multiple states (e.g., PA, NJ, DE)^d, the administrative burden associated with licensure laws may nevertheless deter physicians from utilizing telehealth modalities, especially if telehealth consults would represent a relatively small portion of their overall business.

^b For more info, see: <https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf> 129 STAT. 97

^c This final rule revises the Medicaid home health service definition consistent with Section 6407 of the Patient Protection and Affordable Care Act of 2010 (ACA) and Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

^d According to the Federation of State Medical Boards (FSMB), approximately 20 percent of physicians in the United States hold more than one active state license. See: Young A, et al (2013). A census of actively licensed physicians in the United States, 2012. *Journal of Medical Regulation*, 99(2): 13-24.

A compromise developed and promoted by the Federation of State Medical Boards (FSMB) is a credentialing verification service to assist clinicians seeking licenses in more than one state. In addition, under a grant from the Health Resources and Services Administration (HRSA), the FSMB has drafted a model interstate licensure compact that would allow state medical boards to retain their disciplinary authority, but offer a streamlined licensing process for physicians interested in practicing medicine in multiple states. The compact aims to expand the use of telehealth to deliver care. As of January 2016, 26 state legislatures have introduced model compact legislation; 12 have enacted such a compact.²⁴

III.C. CREDENTIALING AND PRIVILEGING

A second challenge for broader uptake of telehealth relates to hospitals' organizational responsibilities for verifying the qualifications of providers utilizing their facilities and for defining the scope of services each clinician has the authority to render therein. These processes are known as credentialing and privileging, respectively. Since telehealth transactions often involve providers communicating from two different hospitals, there had been a question as to which facility has primary responsibility for credentialing and privileging. In the past, confusion on this point had indirectly impeded the use of telehealth; however, both CMS and the Joint Commission now deem the hospital where a patient is located to have ultimate decision making authority regarding "privileging" for the purposes of care delivered via telehealth. While this would appear to have removed an organizational hurdle to connected care, some concerns linger about telehealth among specialists who object to an originating site having the ability to constrain their authority or scope of practice.

III.D. BROADBAND CONNECTIVITY

Gaps in access to affordable broadband may constrain deployment of telehealth. Some areas still lack access to broadband speeds that may be required for advanced telehealth applications. Broadband deployment in the United States – especially in rural areas – is catching up, but may not keep pace with increasing bandwidth demands of today's high-quality video, graphics and data offerings. The Federal Communications Commission (FCC) reports that fifty-three percent of rural Americans (22 million people) lack access to benchmark service (25 Mbps/3 Mbps).²⁵ While this represents a slim majority of rural Americans, broadband access is still severely underdeveloped on many Indian reservations. At the White House Convening on Rural Telehealth, tribal leaders explained with great frustration that telecommunications companies often build broadband access right up to the border of a reservation and stop. It may be insufficient funding or the administrative burden of obtaining right-of-way permits that keeps telecommunications companies from investing in the broadband infrastructure needed to bring telehealth to tribal lands.

An even greater challenge may be affordability. The price of broadband services can be three times higher in rural areas than in urban areas.²⁶ The FCC and the U.S. Department of Agriculture (USDA) have programs that can support broadband deployment in rural areas and offset high telecommunications costs. However, the ability for health care providers to tap into these resources, particularly through the FCC, is a challenge due to the application process and level of cost sharing as well as a complex mechanism for pulling down funding through a telecommunications provider. The President's Broadband Opportunity Council focuses on federal efforts to address broadband connectivity challenges; HHS has been an active participant in the Council.

It is also important to note that in addition to geographic variation in access to and affordability of broadband services, a sizable percentage (approximately 40 percent in 2015) of older Americans do not use the Internet.²⁷

IV. FEDERAL TELEHEALTH ACTIVITY

IV.A. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HHS' largest telehealth investments are in the form of payments for health care services through Medicare, Medicaid, and the Indian Health Service (IHS). Other HHS Operating Divisions including HRSA, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and ONC also support telehealth activities, the development of mobile technologies (such as remote sensors), or research that assesses the effectiveness of care delivered remotely. Below is a brief sample of HHS's 2015 telehealth activities, followed by more in-depth discussion of some key initiatives. ONC, in collaboration with the Office of the Advancement of Telehealth at HRSA, is compiling a more comprehensive inventory of federal telehealth activities, which is expected to be completed this fall.

- HRSA administers a range of telehealth-specific programs, which include \$10 million in telehealth network grants along with \$4.5 million for a national network of telehealth resource (technical assistance) centers, \$900,000 for Veterans' telehealth, \$750,000 for telehealth research, and \$500,000 in grants to address cross-state licensure challenges. In addition to these specific programs, the agency works to promote and support the use of telehealth by many of its health center grantees. For instance, some HRSA award recipients, such as teaching health centers, funded through the Teaching Health Center Graduate Medical Education program, provide training in the use of telemedicine for primary care. In the Health Center Program, applicants are asked to enhance telehealth services as appropriate to ensure that especially patients in rural areas have access to needed care.
- SAMHSA invested \$3.6 million in grants to support behavioral telehealth and care coordination. The agency also funded an approximately \$150,000 contract to develop a guide on behavioral telehealth financing strategies.
- CDC provided an estimated \$2 million for the ePathology and advanced diagnostics program to link pathologists to public health providers and facilitate real-time consultations regarding infectious disease.
- The CMS Innovation Center is engaged in telehealth activities through the Health Care Innovation Awards (HCIA) and the State Innovation Models (SIMs) initiative. Eight states have included telehealth in their SIM proposals with activities ranging from behavioral telehealth to telecardiology and teleneurology.^e HCIA has included 22 projects with a telehealth focus including projects focusing on chronic care management, remote patient monitoring, E-ICU services, and post-hospitalization care. CMS' rapid cycle learning efforts on these projects may provide more information on clinical and cost effectiveness.
- NIH supported more than 350 extramural and intramural research projects that develop, evaluate, or utilize a telehealth modality.

^e States using SIM for telehealth activities include Colorado, Idaho, Hawaii, Oregon, Pennsylvania, Montana, Utah, and Vermont.

FedTel

Over the last several years, the majority of work by the federal government on the issue of telehealth has been monitored by an interagency task force established by the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP). The Federal Telemedicine Working Group (FedTel) was established in April 2011 to help discuss and reduce organizational silos, facilitate telehealth education and information sharing amongst members, and summarize key telehealth activities of the participants. The current membership includes over 100 participants from 26 agencies and departments including the FCC, USDA, Justice, Commerce, Education, Transportation, the VA, Agriculture, Defense, Health and Human Services (AHRQ, CDC, CMS, the Food and Drug Administration, HRSA, IHS, NIH, the Assistant Secretary for Planning and Evaluation, the Assistant Secretary for Planning and Response, ONC, and SAMSHA), Labor, the National Aeronautics and Space Administration, and the National Science Foundation. This workgroup convenes every other month via conference call and semi-annually face-to-face. HRSA's primary responsibility within FedTel is to internally share funding opportunities and announcements for telehealth research and planning activities throughout the federal government.

ONC Activities: E-health

In the Federal Health IT Strategic Plan released on September 21, 2015, ONC recognized the growing call among consumers and clinicians for “technological innovations such as telehealth ... virtual care models”.²⁸ It also noted that person-centered delivery system reforms are driving interest in telehealth and virtual visits. This rising demand underscores the importance of achieving interoperability to ensure continuity of care and promote better coordination across providers. In response to this demand, the Department will strive to have its interoperability efforts keep pace with evolving telehealth technologies.

As mentioned above, ONC is developing a first-of-its-kind inventory of federal telehealth activities. A questionnaire distributed to federal agency participants in June 2016 will inform federal planning and coordination related to telehealth. The items in the questionnaire seek to ascertain ways in which telehealth activities are supported by different agencies government-wide, to eliminate duplication of effort, and to identify programmatic synergies and complementary efforts. The survey will also shed light on the ways in which different agencies and offices are planning to foster specific kinds of telehealth services, such as remote monitoring or store and forward technologies. Data collection for this project is expected to be completed by the end of July 2016, with the compendium expected to be completed in the fall.

AHRQ's Evidence Map

AHRQ recently commissioned a high-level overview of the literature to assess the existing evidence on the benefits and costs associated with telehealth.²⁹ This Evidence Map was finalized and published June 30, 2016. The report notes that approximately one-quarter of telehealth “encounters” use videolinks; one-quarter involve asynchronous communications (e.g., personal emails, “store-and-forward” image transmission); and less than 5 percent involve the use of a mobile phone.^f Fewer than one in four telehealth services appear to be digitally transmitted images or diagnostic output (e.g., EKG, EEG, MRI, etc.) sent between providers for consultation purposes (where no patient is present for the consult).

^f This estimate regarding the use of tablets and smartphones is likely to be very conservative because AHRQ looked at telehealth studies published as far back as 2006 and up until May 2015. As points of reference, the iPhone was first released in 2007; the iPad debuted in 2010.

Studies on patient satisfaction have shown almost universally that patients who are able to receive care using telehealth modalities are generally pleased with their experiences and outcomes.³⁰ In terms of the effectiveness of telehealth for specific clinical conditions, AHRQ's Evidence Map suggests there are four particular areas where telehealth has distinct promise. These include behavioral health, dermatology, chronic disease management (e.g., cardiovascular conditions, respiratory disease, diabetes, and stroke), and physical rehabilitation.³¹ Evidence pointing to the successful use of technology to improve access or bolster quality of care exists in other areas, for instance teleradiology, burn care, and surgery support, but the research base in these areas is thinner and less robust.³² AHRQ's June 2016 Evidence Map concludes that telehealth holds great promise for a number of specific chronic conditions, for persons with multiple chronic conditions generally, and for people in need of behavioral health services. However, the report also concludes there is insufficient evidence to judge the cost-effectiveness of telehealth broadly.³³

IV.B VETERANS HEALTH ADMINISTRATION

Department of Veterans Affairs

Although this report focuses on telehealth policy and activities within HHS, we briefly discuss the current status of telehealth within the U.S. Department of Veterans Affairs (VA), since the VA is currently the largest provider of telehealth services in the country. The VA began piloting different forms of telehealth at 30 medical centers in 1994.³⁴ A decade of efforts at the local level helped inform a broader VA initiative, which commenced in 2004 to coordinate the delivery of care to veterans using telehealth modalities.³⁵ In Fiscal Year 2014, the VA reported 2.1 million telehealth encounters, with nearly 45 percent of these "visits" involving veterans living in rural areas of the country.³⁶ The VA's telehealth programs currently provide access to 44 different clinical specialties, such as psychiatry, radiology, endocrinology, and neurology.³⁷ In addition, the VA provides tele-emergency care, tele-ICU services, and tele-amputation care to its beneficiaries. During the last eleven years, the VA has invested heavily in developing and deploying the infrastructure needed for its three national telehealth platforms:³⁸

- Clinical Video Telehealth (CVT) - uses real-time interactive video conferencing, sometimes with supportive peripheral technologies, to assess, treat and provide care to a patient remotely;
- Home Telehealth (HT) - applies care and case management principles to coordinate non-institutional care using health informatics, disease management, and home remote monitoring technologies to manage diabetes, chronic heart disease, hypertension, obesity, and traumatic head injuries; and
- Store and Forward Telehealth (SFT) - uses technology to acquire and store clinical information (data, image, sound, or video) that is forwarded to providers such as cardiologists, ophthalmologists, dermatologists, or pathologists at a distant location for clinical evaluation.

These programs now link 152 VA medical centers and over 600 community-based outpatient clinics, using over 6,600 commercial off-the-shelf videoconferencing units. CVT has been expanding especially rapidly in recent years, providing in-home access to care for any Veteran with broadband access.³⁹ The number of in-home video consultations with veterans has grown almost eight-fold

between FY2009 and FY2015 and the vast majority of patients (89-95 percent) reported satisfaction with their care experience.⁴⁰

It is important to note some key distinctions between the VA and other health care settings. These distinctions have facilitated more extensive implementation of telehealth within the VA. Most importantly, the VA is a closed system, with a defined patient population. Doctors are salaried employees and are not competing for patients. This structure promotes cooperation, coordination, and interoperability including a unified electronic health record system, which fosters better communication and continuity of care and program integrity concerns that may occur in fee-for-service settings are less likely. Finally, the VA, by virtue of being “closed,” is generally able to “regulate its own” providers. Unlike non-VA physicians who must be licensed in each state and credentialed by each separate institution where they practice, VA doctors are permitted (because of federal supremacy) to maintain just one active, unrestricted state license in order to practice in any VA facility in the states or the territories. Similarly, providers need only be credentialed once.

V. DEPARTMENT’S CURRENT LEGISLATIVE PROPOSAL

One way in which HHS coordinates policy across a wide variety of topical areas is through the Department’s annual legislative proposal development process. A legislative proposal related to telehealth that illustrates this coordination has been included in the President’s budget request for Fiscal Year 2017.

Currently, the Medicare fee-for-service program covers telehealth services for a defined list of just under one hundred treatments, and requires services be delivered via videolink to beneficiaries living in rural areas. The Department’s proposal would encourage wider appropriate delivery of telehealth services by expanding the ability of Medicare Advantage organizations to deliver certain medical services, at the Secretary’s discretion, via telehealth by eliminating otherwise applicable Part B requirements that certain covered services be provided exclusively through face-to-face encounters. At the same time, it would maintain beneficiary discretion as to the decision to utilize the telehealth benefit.

ENDNOTES

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