

April 21, 2017

Portland VA Research Foundation
Scientific Resource Center
ATTN: Scientific Information Packet Coordinator
P.O. Box 69539
Portland, Oregon 97239

RE: *Supplemental Evidence and Data Request on Telehealth for Acute and Chronic Care Consultations, 82 FR 15057 (March 24, 2017)*

Dear Sir/Madam:

The Connected Health Initiative (CHI) appreciates the opportunity to provide input to the Agency for Healthcare Research and Quality (AHRQ) to inform its review on *Telehealth for Acute and Chronic Care Consultations*, which is currently being conducted by the AHRQ's Evidence-based Practice Centers (EPC) Program.¹ CHI is the leading effort by connected health ecosystem stakeholders to bring about the use of connected health innovations throughout the continuum of care in a responsible and secure manner in order to create an environment in which patients and consumers experience improved health outcomes.²

We believe that an accurate evidence map for decision-making requires an inclusive evaluation of data regarding the potential connected health technology holds to improve acute and chronic care consultations. Without a broader review, AHRQ's review will not provide a complete evidence map and could skew policy decisions.

¹ *Supplemental Evidence and Data Request on Telehealth for Acute and Chronic Care Consultations, 82 FR 15057 (March 24, 2017).*

² See <http://connectedhi.com/>.

Ample evidence exists (and continues to grow) clinically demonstrating telehealth and remote patient monitoring (RPM) of patient-generated health data as cornerstones of advanced healthcare systems, particularly with respect to acute and chronic care consultations. The benefits of connected health's heightened use include improved care, reduced hospitalizations, avoidance of complications, and improved satisfaction, particularly for the chronically ill. A prominent example of the use of RPM is the virtual chronic care management by the Department of Veterans Affairs, which found use of RPM led to a substantial decrease in hospital and emergency room use.³ There is also a growing body of clinical evidence documenting cost savings, noted most recently by a study predicting that remote monitoring will result in savings of \$36 billion globally by 2018, with North America accounting for 75% of those savings.⁴ Both patient outcomes and cost savings are important examinations within this evidence evaluation by AHRQ. We have appended to this letter a non-exclusive list of studies demonstrating the value of telehealth and RPM to patients with acute and chronic conditions.

This AHRQ evidence review comes at a crucial time, as policymakers continue to consider revisions to outdated statutes and regulations that limit the use of evidence-based, patient-centered care delivery, including for telehealth and RPM. A perceived lack of evidence on clinical benefits impedes policymakers' consideration of modifications that would permit evidence-based use of telehealth and RPM. A notable example of the outdated policy barriers to delivery of evidence-based care using telehealth and/or RPM is Section 1834(m) of the Social Security Act which places significant restrictions on telehealth services;⁵ further, remote patient monitoring, independent of telehealth services, is unreasonably restrained by CMS' decision to bundle it with in-person or face-to-face care delivery, defeating the very efficiencies and conveniences that RPM offers patients and providers. As a result, Medicare coverage for telehealth and RPM does not align with clinical evidence,⁶ and incorporation of patient-generated health data (PGHD) through RPM is effectively non-existent.

³ See Darkins, *Telehealth Services in the United States Department of Veterans Affairs (VA)*, available at <http://c.ymcdn.com/sites/www.hisa.org.au/resource/resmgr/telehealth2014/Adam-Darkins.pdf>.

⁴ See Juniper Research, *Mobile Health & Fitness: Monitoring, App-enabled Devices & Cost Savings 2013-2018* (rel. Jul. 17, 2013), available at http://www.juniperresearch.com/reports/mobile_health_fitness.

⁵ See 42 CFR § 410.78.

⁶ For example, according to the Centers for Medicare & Medicaid Services (CMS), Medicare telemedicine reimbursement totaled a mere \$13.9 million in Calendar Year 2014. See <http://ctel.org/2015/05/cms-medicarereimburses-nearly-14-million-for-telemedicine-in-2014/>.

AHRQ is positioned to help the federal government gain insight into the above-noted benefits of telehealth and RPM through this effort. We urge that our comments above, and the appended body of evidence, be considered in AHRQ's efforts.

Please contact the undersigned with any questions, or ways that we may be of help to AHRQ.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian Scarpelli". The signature is fluid and cursive, with the first name "Brian" and last name "Scarpelli" clearly distinguishable.

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