



WISCONSIN LEGISLATURE

P.O. BOX 8952 • MADISON, WI 53708

Testimony before Assembly Committee on Medicaid Reform and Oversight
Assembly Bill 410

Rep. Amy Loudenberg, Rep. Deb Kolste,
Sen. Dale Kooyenga and Sen. Janet Bewley

Thank you, Mr. Chairman and committee members, for the opportunity to testify in favor of Assembly Bill 410.

Wisconsin health care providers are increasingly utilizing telehealth to improve access to essential care. Unfortunately, state laws and policies are not keeping pace with advances in technology and care delivery innovations and are preventing telehealth from reaching its true potential. The recent state budget included some positive reforms that will allow Medicaid to begin reimbursing for telehealth services such as remote patient monitoring and provider-to-provider consultations, but more needs to be done.

This bipartisan legislation was crafted in collaboration with the Wisconsin Hospital Association and the Department of Health Services (DHS) to make changes to how Medicaid covers telehealth. The legislation addresses recommendations from the WHA Telemedicine work group as well as DHS. Our legislation has four main goals to improve Medicaid coverage of telehealth:

1. Require Medicaid to treat telehealth the same as in-person services in terms of coverage for patients and reimbursement for providers.
2. Help Medicaid catch up to Medicare in the number of telehealth services it covers. There are currently more than 50 separate telehealth services Medicare covers that Medicaid does not.
3. Allow Medicaid patients to receive telehealth directly in their homes or other non-clinical settings.
4. Repeal the added layer of telehealth certification that has been a barrier to expanding access to behavioral health, mental health and substance use disorder counseling services for Medicaid patients.



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Assembly Amendment 1 is a technical amendment which all four authors worked on with DHS and WHA to clarify language in the bill that requires any telehealth service that Medicare covers to be covered by Medicaid as well. There are some services that Medicare covers that Medicaid does not, so this amendment adds guard rails to make sure the state isn't paying for non-federally reimbursed services.

A growing body of evidence suggests that you can expand access to telehealth without increasing costs. This is because telehealth is not adding a new type of health care service; rather, it is a different way to access health care services that are already available. We want to continue to support the development and testing of innovative health care payment and service delivery models that reduce the cost of healthcare to both the patient and the taxpayer.

There are several stakeholder groups here today with an interest in this legislation. They each serve a variety of patient populations who may use telehealth. We believe they'll be able to highlight the need for this legislation for their specific patient populations and delivery systems.

Thank you for your time today. We would be happy to answer any questions at this time.



State of Wisconsin
Department of Health Services

Tony Evers, Governor
Andrea Palm, Secretary-designee

TO: Members of the Assembly Committee on Medicaid Reform and Oversight

FROM: Lisa Olson, Legislative Director

DATE: September 24, 2019

RE: 2019 Assembly Bill 410, relating to coverage of services under Medical Assistance provided through telehealth

Good afternoon, Chairman Summerfield and members of the Assembly Committee on Medicaid Reform and Oversight. My name is Lisa Olson. I am the Legislative Director at the Wisconsin Department of Health Services. With me today is Pam Appleby, Director for the Bureau of Benefits Management within the Medicaid program. I am pleased to provide testimony in support of AB 410, which will support the Department in expanding health care access through telehealth services.

The way health care is delivered is changing rapidly in Wisconsin. Leaders across the state are developing new and innovative ways to deliver high-quality care to patients at the right time and in the right place, and they are eager to begin or continue leveraging new telehealth technologies.

Currently, Medicaid reimburses health care providers for services delivered via telehealth in limited circumstances. For example, Medicaid can only pay for certain services as long as patients receive care from certain providers in certain locations—but not their home. Further complicating this dynamic, mental health providers are required to obtain an additional telehealth certification from the Department's Division of Quality Assurance.

Governor Evers' budget required the Department to expand access to telehealth services for Medicaid recipients. Specifically, he directed the Department to develop policies to allow payment for provider-to-provider consultations and other asynchronous transmissions of digital clinical information to capture services that are not delivered at the same time.

Building on the Governor's leadership, AB 410 includes a number of fundamental changes to increase use of telehealth services. First, the bill will allow Medicaid to reimburse for remote patient monitoring services. It will ensure that Medicaid can reimburse for the same telehealth services that Medicare covers, and will also ensure that existing Medicaid services are reimbursed if they are delivered via telehealth. Second, the bill will allow patients to receive telehealth services at home or at school, or other locations, meaning Medicaid will no longer be required to restrict payment based on the location of the Medicaid member. Lastly, the bill removes outdated telehealth provider certification requirements, which go beyond what is required for providers seeing patients face-to-face. We at the Department believe these changes will increase access to vital services, including behavioral health services, for people living across the state, in rural and urban locations alike.

We have heard from Medicaid providers that they are eager to begin using telehealth more broadly, particularly in the behavioral health space.



This legislation will repeal the prohibition on providing treatment for opioid use disorder via telehealth, which will allow more people to receive treatment, including those that live in more rural parts of the state with fewer behavioral health providers. This change – and the others included in this legislation – aligns with the Department’s broader effort to address the opioid crisis.

We expect that this legislation, if passed, will allow for more people, in more areas of the state to receive these critical, life-saving treatments.

The Department has prioritized increasing access to treatment services in high need areas. This bill is an important next step in not only closing the treatment gap in resource deficient areas, but also increasing access among communities statewide. By expanding access through the Medicaid program, AB 410 will spread resources to areas where they are most needed.

We have appreciated the opportunity to work with the bill authors throughout the development of this legislation, and also appreciate the Governor for paving the way for this discussion. Thank you for hearing this important bill and for the opportunity to testify. We are happy to answer any questions you may have.



St. Vincent St. Mary's St. Nicholas St. Clare

On behalf of our four hospitals in Wisconsin, Hospital Sisters Health System (HSHS) Eastern Wisconsin division appreciates the opportunity to submit these comments on telehealth. HSHS first started offering telehealth services in 2016, and that year, we had a total of 80 telehealth patient visits. Today in 2019, we are facilitating over 200 telehealth visits per month at our hospitals. As you saw in the video, we offer a variety of telehealth services. The telehealth service I would like to concentrate on today is our substance use treatment program through Libertas, a nonprofit, fully licensed and accredited, substance use treatment provider. Libertas is based on the philosophy that addiction is an identifiable and treatable disease.

In 2015, Libertas in collaboration with Prevea Health, received the WI DHS Heroin Opioid Prevention Education (HOPE) Grant. This grant provides HOPE services to residents of Florence, Marinette, Menominee and Oconto Counties. In 2018, Libertas was also awarded a WI PSC Telemedicine Equipment Grant to expand HOPE services to 10 locations via telehealth in these counties. The telehealth program would allow patients with opioid and/or methamphetamine use disorder in rural and underserved northeastern Wisconsin to access abstinence-based treatment or medication-assisted treatment with substance use counseling. This telehealth equipment will remove a significant travel obstacle for HOPE individuals and help patients overcome addictions with best practice evidence based treatment by giving them access to Libertas clinicians at multiple locations closer to home. The goals of our Libertas telehealth program are to improve patient access to care, reduce travel time to appointments, save lives and improve outcomes, reduce the need for rural patients to travel to metropolitan hospitals for a higher level of care, reduce delays in care decisions and treatment, increase patient satisfaction and increase care efficiency in rural areas with limited resources.

Since being awarded the telehealth equipment grant in 2018, we have been working to implement our telehealth program. We have deployed the telehealth equipment to the 10 sites and now are working on the regulatory requirements. In order to provide behavioral care telehealth services we need to certify all 10 locations as branch sites under both our Libertas and Prevea Health certifications. In addition to the branch site certifications, we need to complete the WI Medicaid Behavioral Health Telehealth Certification again for both Libertas and Prevea Health. This certification is a duplication of many of the requirements we already need to obtain for the branch site certification and includes other telehealth specific elements as well. This includes adding a requirement that any room that will be used for telehealth has a lock on it, which can be a safety risk for our healthcare team, creating telehealth specific policies, annual telehealth training which includes the history of telehealth, and listing any providers that would be participating in telehealth visits. This has added extra steps to implementing the telehealth program and has delayed our implementation.

Behavioral Care is the only telehealth program that requires a separate telehealth certification. Healthcare is already highly regulated and telehealth services are just a different way we are providing healthcare for our patients. This certification is only adding additional regulations and costs for us to care for an underserved, vulnerable patient population.

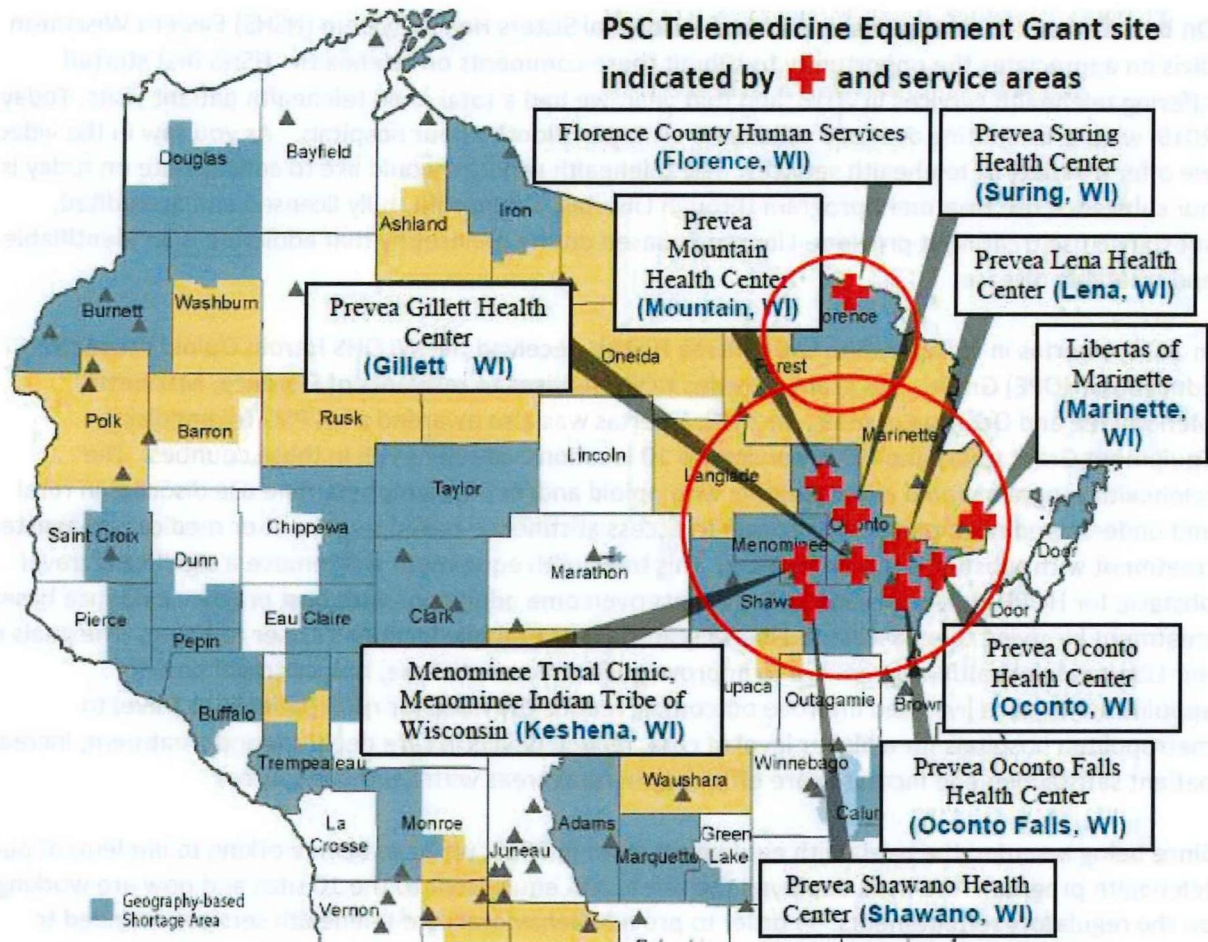
We hope you will help us change the telehealth law so more services can be covered and more people in Wisconsin can be served. Thank you for considering this bill and the impact it will have on the people of Wisconsin.

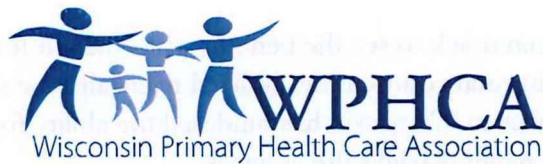


St. Vincent St. Mary's St. Nicholas St. Clare



PSC Telemedicine Equipment Grant site indicated by + and service areas





September 24, 2019

TO: Chairman Rob Summerfield
Members of the Assembly Committee on Medicaid Reform and Oversight

RE: 2019 Assembly Bill 410 (2019 SB 380); coverage of services under Medical Assistance provided through telehealth and other technologies

On behalf of the Wisconsin Primary Health Care Association (WPHCA), I am writing to express support for 2019 Assembly Bill 410 (2019 SB 380).

The Wisconsin Primary Health Care Association believes that this legislation opens up avenues to increase patient and provider utilization of telehealth services for Medicaid/BadgerCare patients. More specifically it:

- Increases access to care for Medicaid/BadgerCare patients by reducing transportation, physical distance and mobility barriers.
- Increases the ability of Community Health Centers and other providers to provide telehealth services by reimbursing them for telehealth services at their Medicaid rate for in-person services and removing administrative barriers.
- Increases patient access to mental health and substance use disorder services.

Increases Access to Care by Reducing Patient Barriers

Community Health Centers serve over 300,000 patients in communities throughout the state. 57% of those patients receive health coverage through Medicaid.¹ Per federal law, Health Centers are required to provide comprehensive services in high need areas, where many patients face geographic, economic, transportation, and other barriers to health care. Patients, especially those in rural, sparsely populated areas face long travel times between their home and a health care provider. Increasing patient access to health care via telehealth is an important step in reducing barriers to care.

Increases the Ability of Community Health Centers to Provide Telehealth Services through Adequate Reimbursement and the Removal of Administrative Barriers

Over the years Community Health Centers across the nation have begun offering telehealth services in their centers to increase care access avenues for their clients. Nationally, roughly 40% of Health Centers offer needed services or help patients monitor their chronic conditions through telehealth.² Health Centers

¹ Health and Human Services, Health Resource Services Administration Uniform Data System.

² The National Association of Community Health Centers. "Snapshot: The Health Center Program is Increasing Access to Care through Telehealth." February 2018. http://www.nachc.org/wp-content/uploads/2018/02/Telehealth_Snapshot_FINAL_2.22.18.pdf

in rural communities have been quick to see the benefits of telehealth for their patients, and nationally nearly half of health centers in rural communities utilized telehealth for services outside the clinic.³ However, reimbursement policy in Wisconsin has hindered the ability for the majority of Community Health Centers to offer their patients telehealth services.

This legislation would reimburse Community Health Centers for telehealth services at their Medicaid rate, allowing them to expand access to care to more people. Along with reducing administrative barriers, this is a critical step in promoting the expansion of telehealth and ensuring long-term sustainability of these services in Community Health Centers.

Increases Access to Mental Health and Substance Use Disorder Services

Community Health Centers have increased their capacity to provide mental health and substance use disorder treatment and recovery services in response to the needs of their communities. Patient visits for these services have tripled since 2003. The need for these services coupled with provider shortages have Community Health Centers searching for alternative strategies to meet the demand. This legislation will allow Health Centers to use telehealth and particularly telepsychiatry for patients who may otherwise not be able to access mental health and substance use services.

Community Health Centers are continuously seeking creative and cost-effective ways to remove barriers to care for their patients. Expanding Medicaid coverage for telehealth services will help Community Health Centers and other providers increase access to a range of quality health care services for more communities experiencing provider shortages and barriers to care.

Sincerely,



Stephanie Harrison, CEO
Wisconsin Primary Health Care Association

ABOUT WPHCA:

WPHCA is the membership association for Wisconsin's 17 Federally Qualified Health Centers (FQHCs) also known as Community Health Centers (CHCs). Community Health Centers work to create healthier communities by improving access, providing quality health care and reducing health disparities for Wisconsin's underserved and low-income populations. Our aim is to ensure that all Wisconsinites achieve their highest health potential. We execute our mission and focus our aim through providing training and technical assistance to Wisconsin's Community Health Centers and advocating on their behalf.

³ Ibid



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Assembly Committee on Medicaid Reform and Oversight
Testimony in support of AB-410
Provided by Thomas B Brazelton III, MD, MPH, FAAP
Professor of Pediatrics, University of Wisconsin School of Medicine and Public Health
September 24, 2019

Dear Chairman Summerfield and members of the committee:

Thank you for the opportunity to appear before you today. We are representing UW Health where I serve as Medical Director of the Telehealth Program and President of the Medical Staff. I am joined by Rachel Zorn, Telehealth Manager. We are here in support of Assembly Bill 410 and our goal is to explain the direct impact this bill would have on our ability to embed telehealth services into our health care model to better meet the needs of our patients and communities. We hope the information we share will convince you to join us in support.

As currently written, AB-410 would remove state Medicaid policies that limit telehealth coverage of otherwise reimbursable Medicaid-covered services. It would also require Medicaid to reimburse for telehealth services when delivered to the patient's home or other non-clinical environments. We wholeheartedly support this as it would help to decrease (a) long wait times patients currently experience to see their provider, (b) time off from work for patients (c) long distances traveled to receive health care services, and (d) the additional burden on family members who often coordinate and/or accompany patients to and from appointments.

At UW Health we developed a program, using evidence-based telehealth technology, to provide same-day access to non-dilated eye screening for adult patients with diabetes. A retinal camera is co-located with primary care clinics and the images are sent via store and forward technology to an Ophthalmologist to interpret. With this program we reduce patient travel and time away from work for a separate appointment with the specialist. We can also increase the efficiency for patients who need to be seen in Ophthalmology clinic as we convert clinically-appropriate in-person visits to high quality, efficient telehealth modalities. Ophthalmology is a growing need in our community, especially for individuals with diabetes. Diabetic retinopathy is the leading cause of blindness in working-age Wisconsin adults and ninety percent of blindness can be prevented through early identification and treatment. Currently, only 50% of diabetic adults meet screening guidelines for retinal evaluation every one or two years, mostly because of the delays associated with in-person screening.

Within the first year of our Dane County program we identified diabetic retinopathy in 17% of screenings and improved access to services from *weeks* to see an Ophthalmologist in person to 2.1 days with the Teleophthalmology service. Financially this amounts to \$6,680 in annual cost savings per patient due to earlier detection and treatment. The Teleophthalmology program is succeeding not only because there is an evidence-based, telemedicine technical solution to address a growing patient and community need, but also because

there is policy and payment to support this model of care. Wisconsin Medicaid and most commercial insurers cover this preventive service, providing our patients and providers an appropriate incentive to meet the standard of care and improve patient access.

AB-410 would allow us to replicate this success we have seen in Teleophthalmology to other essential, and no less impactful, areas. For telehealth, improved patient access leads to better outcomes and can only support the health and economic vitality of our communities, especially in the rural areas where access to specialty care is so limited.

Other examples of where expanded access to telehealth will improve outcomes include:

1. **Prenatal visits:** Offer telehealth to women with low risk pregnancies; provide more convenient options to support women through a healthy pregnancy while still participating in the workforce. Telehealth can reduce the burden to decide between taking time off work to travel for in-person prenatal care or the potential impact of missed appointments on her and her child's health.
2. **Children with complex needs:** Telehealth brings the specialized care to patients residing in rural and physician shortage areas and diminishes the disruption to normal daily living for the patient, care givers, and siblings. reducing time off from work for parents and legal guardians, school absences for the patient and siblings, and need for additional childcare coverage.
3. **Specialty eConsults:** Primary care providers often need specialty consults but they historically have required the patient to see the specialist in person. With eConsults, the primary care provider can have those questions answered within 2 days, saving the patient weeks of angst while waiting for the specialist appointment, often saving the need for specialty appointments and unnecessary or repeat testing.
4. **Complex patients in the home:** With remote patient monitoring, our most fragile and medically complex patients can be managed in their homes safely, reducing unnecessary clinic or ER visits and decreasing readmissions by up to 75%, improving their quality of life while reducing the cost of their care.

In conclusion, we support this bill because it helps us improve the way we deliver care to our Medicaid patients, which in turn supports healthier, more productive communities. Enactment of AB-410 will mean an opportunity to expand health care through increased access, uncompromised quality of care, patient-and family centered services, delivered at the right time and to the right place.

Thank you for your time and your interest in our support for AB-410. We are happy to respond to questions.

Selected References:

- American Optometric Association. Evidence-based clinical practice guideline. In: Evidence-based Optometry Guideline Development Group. Eye care of the patients with diabetes mellitus. St. Louis, MO: American Optometric Association, 2014:2–83.
- Liu Y, Rajamanickam VP, Parikh RS, et al. Diabetic Retinopathy Assessment Variability Among Eye Care Providers in an Urban Teleophthalmology Program. *Telemed J E Health*. 2019;25(4):301–308. doi:10.1089/tmj.2018.0019.
- Wittenborn, J, Rein, D. Cost of Vision Problems: The Economic Burden of Vision Loss and Eye Disorders in the United States. *Ophthalmology*. 2013 Sep;120(9):1728-35. doi: 10.1016/j.ophtha.2013.01.068. Epub 2013 Apr 28.

Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

Assembly Bill 410 Assembly Committee on Medicaid Reform and Oversight September 24, 2019

Chairman Summerfield, members of the Committee, thank you for the opportunity to testify today. My name is Tim Lundquist and I am the Director of Government and Public Affairs at the Wisconsin Association of Health Plans. The Association is the voice of 12 Wisconsin community-based health plans that provide employers and individuals across Wisconsin access to high-quality health care. Many of these health plans also partner with the state through Medicaid Managed Care, where they collectively serve 220,000 individuals in Wisconsin's Medicaid programs.

Community-based health plans recognize the value of telehealth, and support expanded coverage and reimbursement of telehealth services in Medicaid. However, Assembly Bill 410 as currently drafted, creates questions about the broad impact of telehealth expansion.

- **Program Cost** - What is the anticipated impact of AB 410 on utilization, and what is the corresponding impact on program cost? How will the reimbursement changes included in AB 410 impact the capitation rates paid to Medicaid HMOs?
- **Impact of Payment Parity** - 49.45(61)(e) provides that the Department of Health Services "shall pay for services provided under par. (b) by a certified provider of Medical Assistance at a distant site an amount equal to the amount the certified provider would receive under the Medical Assistance program if the service were provided through a method other than telehealth."

If reimbursement levels for providers making an identical diagnosis can vary based on the location of care provided, whether via **clinic, critical access hospital, or provider-based billing facility**, will this provision incentivize the delivery of telehealth from higher-cost locations?

To limit the potential fiscal impact of this provision, community-based health plans recommend the Committee consider amending the bill to either: (1) cover the lowest amount in the Medicaid fee schedule for the service provided, or (2) exclude additional payments for provider-based billing and critical access hospitals. The Committee could also consider providing the Department of Health Services rulemaking authority to create some guardrails around the parity provision.

AB 410 represents an important opportunity to advance coverage and reimbursement of telehealth services in the Medicaid program. I look forward to learning how other stakeholders and Committee members understand the impact of this legislation. I would be happy to answer any questions the Committee may have.



Greater Wisconsin
Agency on Aging Resources, Inc.

Date: September 22, 2019

To: Chairman Summerfield, Vice Chairman Brooks, and Members of the Committee on Medicaid Reform and Oversight

From: Janet L. Zander, Advocacy & Public Policy Coordinator

Re: Support for AB 410/SB 380 – Relating to: coverage of services under Medical Assistance provided through telehealth and other technologies, extending the time limit for emergency rule procedures, and granting rule-making authority. (FE)

The Greater Wisconsin Agency on Aging Resources (GWAAR), is one of three Area Agencies on Aging in Wisconsin. We provide training and technical assistance to support the successful delivery of aging programs and services in 70 counties (all but Dane and Milwaukee) and the 11 tribes in Wisconsin. GWAAR is also a member of the Wisconsin Aging Advocacy Network (WAAN), a collaborative group of older adults and professional aging associations and organizations – including the Wisconsin Association of Area Agencies on Aging, the Wisconsin Association of Senior Centers, the Wisconsin Association of Nutrition Directors, the Wisconsin Association of Benefit Specialist, the Aging & Disability Professionals Association of Wisconsin (representing aging unit/ADRC directors and managers), the Wisconsin Adult Day Services Association, the Alzheimer's Association Wis. Chapter, the Wisconsin Institute for Healthy Aging (WIHA), the Wisconsin Senior Corps Association (WISCA), and the Wisconsin Tribal Aging Unit Association.

Thank you for this opportunity to share testimony on AB 410/SB 380 relating to coverage of services under Medicaid provided through telehealth and other technologies. "Telehealth" - a practice of health care delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communication - has long been a covered service under Medicare. In fact, there are more than 50 separate telehealth services covered by Medicare. Many state Medicaid programs also cover an increasing number of telehealth services. Wisconsin's current Medicaid policies limit coverage of telehealth services. AB 410/SB 380 aims to remedy this by "requiring the Department of Health Services to provide reimbursement under the Medical Assistance program for any benefit that is covered under the Medical Assistance program, delivered by a certified Medical Assistance program, and provided through interactive telehealth." Additionally, the legislation allows patients enrolled in Medicaid to receive telehealth directly in their homes or other non-clinical settings.

Telehealth is a different way to access health care services (not a new type of service). Telehealth services offer patients (especially those living in rural areas or those who are homebound) to receive basic, on-demand care without the transportation costs and time needed for a customary in-person office visit. Telehealth services may be more convenient and accessible for some patients who, under this bill, would now be able to receive care via video conferencing, smartphone apps, and online management systems. Receiving care when it is needed, rather than waiting for an office

appointment, has been shown to reduce unnecessary non-urgent emergency room visits. Telehealth also offers patients in rural or remote areas quicker and more convenient access to specialist care without the need to travel long distances (and without the Medicaid program paying for non-emergency medical transportation for patients who need it).

Advances in technology and care delivery innovations have helped to increase access to essential care for many older adults receiving Medicare benefits. We support AB 410/SB 380 to help improve access to care by providing Medicaid coverage of telehealth services for low-income, older adults (some of whom are not yet eligible for Medicare) and Medicaid participants of all ages.

Thank you for your consideration of these comments supporting AB 410/SB 380.

Contact: Janet Zander, Advocacy & Public Policy Coordinator
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(715) 677-6723 or (608) 228-7253 (cell)



TO: Members of the Assembly Committee on Medicaid Reform and Oversight
FROM: The Wisconsin Association for Home Health Care
DATE: September 24, 2019
RE: Please Support Assembly Bill 410

The Wisconsin Association for Home Health Care (WiAHC) is a membership-based association that represents home health care agencies and their staff. WiAHC helps to support the common interests of its members to promote home health care as a quality, cost-effective health care option in our state. In Wisconsin there are over 14,000 home health employees that have garnered \$386 million in wages.

Home health care comprises a variety of health care services that can be provided in a patient's home to address an illness or injury. Home care is a convenient option for the individual who can be at home but needs the extra assistance for short-term or long-term care that cannot be provided solely by family or friends. Numerous studies have established that 9 out of 10 people prefer home care over nursing home care.

Workforce availability is an ongoing issue for the healthcare industry. Unfortunately, home health agencies regularly lose highly skilled nurses to other sectors, mostly due to compensation potential. In Wisconsin, RNs are disproportionately represented in nearly all other areas within the healthcare industry. Wisconsin is also well below the national average when it comes to RNs working in home health settings. RNs working in home health settings make up just 6% of the total nursing workforce in the state, according to the Wisconsin Center for Nursing. Nationally, RNs working in home health settings make up nearly 13% of the total nursing workforce, according to the Bureau of Labor Statistics.

Allowing home health agencies to seek Medicaid reimbursement for telehealth services innovatively addresses nursing workforce issues. An average home health agency nurse has a case load of 25 to 30 patients and sees on average 5 to 6 patients per day. Utilizing telehealth would increase access and utilization by allowing nurses to see 8 to 10 patients per day. Additionally, utilizing telemonitoring allows home health agencies to monitor patient health data 24 hours per day. Other states including Minnesota, Indiana, Nebraska, Kansas, and Texas are already utilizing such technology.

Allowing home health agencies to seek Medicaid reimbursement for telehealth services would alleviate financial strain on Wisconsin's home health agencies and address workforce shortages. Please support Assembly Bill 410 and this innovative solution to workforce issues. If you have any questions, please contact WiAHC's government affairs team Tim Hoven and Erik Kanter at 608-310-8833.

Committee on Medicaid Reform and Oversight

9/24/19

Sue Dierksen

AARP Testimony in Support of AB410

Good Afternoon. I am Sue Dierksen from Gleason WI. Thank you for allowing me to testify today. I am here to encourage the committee's support for AB 410, the Telehealth Bill. I serve as one of the volunteer advocates for AARP Wisconsin. Many of our 840,000 members in Wisconsin would benefit from the expanded availability of telehealth practically our isolated rural members and those who do not drive and face transportation challenges getting to a clinic or other health care provider. Today I wish to comment on why AARP Wisconsin supports AB 410 and to share my observations on telehealth from my perspective as a nurse who has practiced in Rural Wisconsin.

AARP WI has a history of supporting increasing access to health care and has supported the use of technology to insure isolated seniors and those with transportation challenges can access quality care. Telehealth is the reason that AARP has been so supportive of broadband expansion. Reliable telehealth availability is a key to better health opportunity for all Northwoods citizens. Health care monitoring via telehealth provides efficient and timely care through face to face discussion with the provider, ability for the provider to visually interact with the patient to assess the overall condition and adjust the plan of care. People/patients can benefit from access to additional telehealth services such as mental health, health education programs and post hospital discharge follow up and monitoring.

In my career as a Registered Nurse I have worked at the corporate level as part of the health benefits team selecting employee health insurance products in addition to implementing effective wellness programs. For the past six (6) years I have lived in northern Wisconsin and worked for a large healthcare system. In my role as Director for Business Health I worked with all the system medical providers and clinics throughout the region to assist local employers in providing better access and timely health care for their employees and families. Through these interactions and my role on various committees and work groups in the health system I became more aware of the barriers patients and providers face in our rural regions related to health care. I also learned of the opportunities that exist through virtual technology to improve healthcare access and health outcomes.

WI has some of the best quality healthcare in the nation, but access to that care is not equally available across the state especially in rural areas such as the northern tier of the state.

The WI population is aging with a large percentage of the population being over 50 y/o and generally experiencing increased chronic health issues as they age. As people age they often forgo driving and therefore transportation becomes an even greater barrier to accessing care.

We understand that Health systems struggle to recruit providers to rural areas adding to the stress of underserved regions and an overload for existing providers.

Urgent care/walk-in care is not meant to treat chronic conditions and therefore are limited in the ability to have a lasting impact on overall health improvement. Yet people will postpone medical care until it is an immediate need and then access an urgent care or an emergency department for care.

Cell phone and/or computer access is increasing for all age groups. Older individuals, generally, are more comfortable with personal face to face or voice to voice communication regarding health care concerns. The information shared and instructions given are more readily retained with a personal interaction. Telehealth provides such interaction in the home setting reducing the stress and need to physically go to a clinic for care.

Telehealth offers an avenue to health care and health education regardless of physical location and transportation barriers. This is a benefit to all citizens regardless of age.

Monitoring of patients with chronic conditions does not necessarily need to be in a clinic to interact with a provider. Multiple computerized medical devices now available provide real time health information to providers but must have reliable internet service to work. The ability to connect via telehealth with the provider to be "examined", review clinic monitoring, and discuss overall health monitoring and adjustments can be very effectively done creating a win-win for all in administering better health care, reducing cost of transportation and services for the patient.

Health systems have also added online/virtual acute care offering for specific common health concerns, leading to faster access, no travel cost and cost effective care.

I believe that reliable telehealth availability is a key to better health opportunity for all Northwoods citizens and other Wisconsinites. Health care monitoring via telehealth provides efficient and timely care through face to face discussion with the provider, ability for provider to visually interact with the patient to assess overall condition and adjust the plan of care. People/patients can benefit from access to additional telehealth services such as mental health, health education programs and post hospital discharge follow up and monitoring.

Please vote to support AB 410. Thank you for your time and consideration.



ADVOCATE. ADVANCE. LEAD.

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TO: Members of the Assembly Committee on Medicaid Reform and Oversight

**FROM: Matthew Stanford, General Counsel
Jon Hoelter, Director Federal & State Relations**

DATE: September 24, 2019

RE: WHA Supports AB 410 and Assembly Amendment 1 – Bipartisan Legislation to Modernize Medicaid’s Telehealth Policies

The Wisconsin Hospital Association supports AB 410 and Assembly Amendment 1, bipartisan legislation introduced by Representatives Loudenbeck and Kolste & Senators Kooyenga and Bewley that better leverages telehealth opportunities to improve access to care, enhance outcomes and reduce costs in the Medicaid program – especially for those living in underserved rural or urban communities.

In July, 90 lawmakers and staff attended a Capitol issue briefing from WHA, hosted by the same group of bipartisan co-authors spearheading Assembly Bill 410, which showed real-world barriers associated with Wisconsin’s current Medicaid telehealth policies. Health care providers talked about their desire to expand cost-saving telehealth services to more patients, but current barriers in Medicaid prevent them from receiving Medicaid reimbursement for providing these services. Behavioral health care was one area in particular where providers noted outdated, unnecessary regulatory barriers have slowed or halted expanding access to behavioral health services through telehealth technology.

AB 410 is the result of recommendations from WHA’s Telehealth Work Group, which included participation from more than 36 WHA rural, suburban and urban members across the state of Wisconsin. WHA’s Telehealth Work Group has spent the past three years reviewing state laws and regulations while also engaging with DHS to find ways to leverage telehealth opportunities to improve access, enhance outcomes and lower costs for the Medicaid program. Through that review, the Work Group developed four recommendations articulated in this bill that will better align Wisconsin’s Medicaid statute with past, current, and future advancements in telehealth:

1. **Treat Telehealth the same as in-person care.** Medicaid should allow all services it currently covers in person to be delivered via telehealth, if provided in a manner functionally equivalent in quality to an in-person visit.
2. **Catch up to Medicare telehealth-related coverage.** Medicare currently covers about 75 more telehealth-related procedure codes than Medicaid and tends to update new telehealth-related codes annually. Our work group recommended that it would be easier to offer telehealth services if clinicians knew both Medicaid and Medicare would cover the same telehealth-related services. This legislation would help Medicaid catch up and keep pace with Medicare in the new telehealth services it covers.

Under this legislation and amendment, Medicare-covered, telehealth-related services automatically become reimbursable Medicaid covered services unless DHS promulgates a rule to exclude a Medicare-covered telehealth-related service.

3. **Cover in-home or community services.** Wisconsin’s Medicaid program is one of only six states that does not allow for reimbursement in a home or community-based setting. Particularly for the Medicaid population, transportation challenges can be a significant barrier for accessing preventative and follow-up care that can avoid costly trips to an emergency department or hospitalization.

By enabling care through telehealth in a home or community-based setting, Wisconsin can improve outcomes and avoid high-cost health care utilization. In fact, WHA's In-Capitol briefing in mid-July provided concrete examples of hospital and health system members who are looking to add in-home telehealth options for Medicaid beneficiaries but have not yet because Medicaid doesn't reimburse for this care.

Under this legislation and amendment, in-home remote patient monitoring and asynchronous (store and forward) telehealth services are required to be reimbursable Medicaid covered services, unless DHS promulgates a rule excluding such service from reimbursement.

4. **Increase access to behavioral health.** Currently there is a statutory requirement that providers receive a separate telehealth certification, in addition to their provider licensure and Medicaid certification, if they want to provide behavioral health services via telehealth to Medicaid patients. No other health service covered by Medicaid requires a separate telehealth certification, creating an additional and unnecessary barrier to critically-needed behavioral health services.

Under this legislation, the separate behavioral health telehealth certification is repealed. However, DHS may require by rule that the transmission of information through telehealth be of sufficient quality to be functionally equivalent to face-to-face contact.

Telehealth creates an opportunity for the Medicaid program to increase access and improve outcomes while maintaining or even reducing program costs.

Medicare, the State of Wisconsin Group Insurance Board, other states' Medicaid programs and private payers have embraced telehealth not only because it improves access to care, but because they have concluded that evidence shows utilization of telehealth improves access while maintaining or lowering the total cost of care.

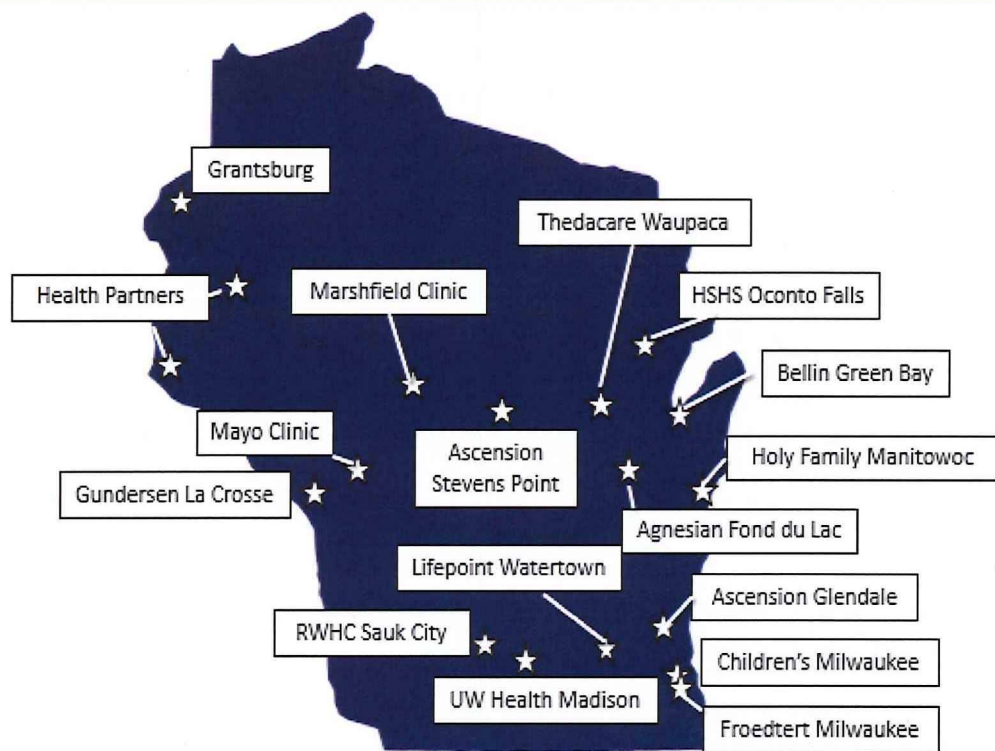
WHA has reviewed, compiled and attached to this testimony multiple sources of evidence that point to a conclusion that the expansion of telehealth services in the Medicaid program will result in no additional net program costs or will lower net program costs. Particularly for underserved Medicaid populations that have travel challenges and chronic conditions, having telehealth options enabled by this bill increases the likelihood that low-cost treatment and management services will be utilized to avoid high cost emergency or hospitalization services.

For example: an expecting, single mom who has a child at home may choose to skip her pre-natal appointment because she's struggling to fit it into her work schedule. Prenatal services, if provided through telemedicine to be delivered at home or even while at work, will provide a more flexible option for a mom trying to juggle a hectic schedule and make ends meet. This basic interaction can encourage prenatal care and help prevent an even more complicated pregnancy or delivery, which can cost the Medicaid program tens or even hundreds of thousands of dollars.

Additionally, telemedicine can directly reduce Medicaid expenditures for non-emergency medical transportation for Medicaid enrollees. On an annual basis, Wisconsin's Medicaid program pays \$100 million to cover transportation costs for Medicaid enrollees – a cost that could be reduced by care being delivered via telemedicine rather than in person.

One primary goal you often hear from health care providers is to deliver "the right care, in the right place, and at the right time" to patients. We are pleased to support this bipartisan telehealth legislation that will advance that goal for patients throughout Wisconsin.

WHA Telehealth Work Group



36 WHA members participated, Representing hospitals and health systems from all over Wisconsin.

Appendix

Evidence on Cost Impacts for Telehealth Benefit Expansion Points to a Net \$0 Impact or Cost Savings on Total Medicaid Benefit Costs

1) The Wisconsin Group Insurance Board concluded that telehealth coverage would not increase program costs.

In May 2018, the Wisconsin Group Insurance Board approved a change to the 2019 state employee health plan that would result in complete coverage of telehealth services. In calculating the cost of adding telehealth as a covered benefit, the Group Insurance Board budgeted the change as having an estimated net program cost of \$0. Some argue that any new telehealth benefits might not accrue to a program in the form of reduced utilization of higher acuity and cost services for multiple years. However, the Group Insurance Board, which budgets on a year to year basis, rejected that theory when it estimated 2019 net costs at \$0.

2) The Federal Medicare program has begun scoring the addition of telehealth benefits at \$0 net cost.

In April 2019, the Medicare program published a final ruleⁱ implementing “additional telehealth benefits” for Medicare Advantage plans that resulted in HHS ultimately reaching the same conclusion as the Wisconsin Group Insurance Board – HHS scored the additional telehealth benefits as a net \$0 impact on the cost of overall benefits.ⁱⁱ

Notably, the Medicare program drew on comments from the experience of Medicare Advantage insurers themselves to reach its conclusions regarding cost:

We received numerous comments from several sources, and the commenters were overwhelmingly supportive. The comments were not subjective but evidence-based, reflecting MA plans’ first-hand experience with telehealth in some of their existing products.ⁱⁱⁱ

Many of the commenters cited similar studies or their own experience. These articles and comments point to a quantitative savings in health care. Although, as mentioned previously, in the early years of telehealth there was concern for overutilization which would raise costs, this does not seem to be a major issue today.^{iv}

Medicare noted one study that purported to show that telehealth increases costs; however, Medicare dismissed that study for several reasons:

Only one article raised this [overutilization] concern, and the article itself listed several drawbacks to its conclusion. More specifically, the article –

- ++ Used data from only one telehealth company;
- ++ Used data on only specific medical conditions;
- ++ Referenced a population study that had a “low uptake of telehealth;” and
- ++ Was from an early period in telehealth.^v

Conversely, Medicare provided examples of specific telehealth savings. For example, its review found that using telehealth for transitional care programs for discharged Medicare patients saved \$1,333 per beneficiary, half of which was due to reduced inpatient follow-up care.

3) Telehealth coverage for Medicaid directly reduces unique Non-Emergency Medical Transportation costs for the Medicaid Program.

Unlike private insurance, the state employee health plan and Medicare, the Medicaid program provides a transportation benefit to Medicaid beneficiaries that has been an annual all funds expense of \$100 million. Also,

unlike other health plans, every time a Medicaid enrollee substitutes a telehealth service – either from home or from a facility closer to home – Medicaid sees a direct cost reduction in the transportation benefit.

4) California analysis of telehealth expansion in the Medicaid program found significant savings to the Medicaid Program.

In 2011, California enacted the Telehealth Advancement Act that allows coverage of telehealth regardless of where it takes place, including programs that employ in-home telemonitoring devices. A cost analysis commissioned during consideration of the bill examined potential savings that would accrue to California's Medicaid program (Medi-Cal) regarding heart failure and diabetes management. It found that:

- In-home telemonitoring for heart failure patients could save \$929 million annually for Medi-Cal (\$8,600 per beneficiary per year).
- In-home telemonitoring for diabetics could save \$417 million annually for Medi-Cal (\$939 per beneficiary per year).^{vi}

5) Alaska began covering home telemonitoring of daily vital signs in 2007. They found a return on investment of nearly 1,500%.

Beginning in 2007, Alaska implemented a home telemonitoring (HTM) program to mitigate substantial geographic barriers to care access in the largely rural state. In the first six years of the program, annual cost of care for program participants fell \$634,365 (from \$676,782 to \$42,417 per year) through reductions in Medivacs, emergency room visits, and hospital readmissions.^{vii}

6) Colorado legislation in 2010 authoring reimbursement for remote monitoring received a fiscal note estimating savings to the Colorado Medicaid program.

In 2010, Colorado's Medicaid program began reimbursing for "the remote monitoring of clinical data through electronic information processing technologies." The fiscal note affixed to the authorizing legislation estimated in-home telemonitoring would save Colorado Medicaid by reducing hospitalizations 10% and keeping Coloradans out of the emergency room.^{viii}

7) A study of Kansas telehealth expansion in the Medicaid program found \$26,000 in cost savings per patient per year attributable solely from reduced hospitalizations.

In 2010, the Center for Telemedicine & Telehealth at the University of Kansas Medical Center published the results from a three-year study tracking outcomes, costs, and utilization associated with Medicaid in-home telemonitoring services provided through a federal waiver. The results demonstrated the use of in-home telemonitoring reduced the rate of emergency room visits, inpatient hospitalizations, nursing facility placements, and associated health care costs. The authors of the study found over \$26,000 in cost savings per patient per year from reduced hospitalizations. In comparison, the cost of equipment was \$816 per patient per year.^{ix}

8) Louisiana's Department of Health and Hospitals examined available research and concluded that new telehealth applications reduce overall costs.

In 2013, the Louisiana Department of Health and Hospitals wrote the following to the House and Senate Health and Welfare Committee chairmen:

Research cites three methods telehealth can produce an economic benefit. The first is patients can avoid hospital transfers by receiving telehealth consultation services, therefore reducing transportation expenses. In emergency situations, like stroke care, telehealth can provide guidance to physicians to administer life-saving drug therapy. The second method is home monitoring of patients with chronic diseases which can result in decreased hospitalizations. Finally, telehealth can enhance the marketability of rural health facilities and keep more health care dollars in the local economy...In addition to telehealth economic benefits, results in patient

health outcomes have been optimal. Recent studies have found that new telehealth applications, such as remote patient monitoring, have reduced overall costs, and improved health outcomes for target populations.^x

9) A New York Study of 53 patients with high hospital utilization found telehealth produced a 42% drop in medical costs.

In 2010, the New York Eddy Visiting Nurse Association (VNA) completed a one-year study of 53 patients with two or more hospitalizations or emergency room visits in the last 12 months that had telehealth units installed in their homes. The study reported the following results:

- 55% drop in the number of hospitalizations, from 178 to 80;
- 29% reduction in emergency visits, from 137 to 97;
- 42% drop in medical costs, from \$3 million to \$1.7 million.^{xi}

10) In 2013, Texas authorized Medicaid coverage of in-home telemonitoring services. In the fiscal note authorizing that coverage, the Deputy Executive Commissioner for Financial Services for the Texas Medicaid program concluded the change would result in cost savings.

The fiscal note determined that the first five-year period of the new coverage would result in cost savings “as the addition of telemonitoring as a Medicaid benefit is anticipated to result in fewer hospital readmissions and emergency room visits.” The note did not identify exact savings that would accrue, but “the report unequivocally states the policy would result in anticipated cost savings.”^{xii}

11) A study of Iowa’s use of telehealth for congestive heart failure management found nearly \$3m in savings in a demonstration program for the Iowa Medicaid program.

A demonstration project of 266 Iowa Medicaid members utilizing telehealth in the management of congestive heart failure found a 24% reduction in hospital admissions, a 22% decrease in total bed days, and nearly \$3m in savings from reduced health care service utilization.^{xiii}

12) A 2015 study concluded that telehealth for individuals with mental health needs improves care and reduces costs.

A study by researchers at the University of Michigan, University of Kentucky, and University of California Davis concluded:

“The published scientific literature on [telemental health] reveals strong and consistent evidence of the feasibility of this modality of care and its acceptance by its intended users, as well as uniform indication of improvement in symptomology and quality of life among patients across a broad range of demographic and diagnostic groups. Similarly, positive trends are shown in terms of cost savings. Conclusion: There is substantial empirical evidence for supporting the use of telemedicine interventions in patients with mental disorders.”^{xiv}

ⁱ Department of Health and Human Services, “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021,” 84 Fed. Reg. 15680 (April 16, 2019) <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>

ⁱⁱ HHS did score a \$6.1m and \$6.1m cost to the Medicare Trust Fund in 2020 and 2021 respectively due to the additional telehealth benefits in the rule for approximately 22 million beneficiaries. However, HHS explains that those costs are not due to the additional benefits but from a transfer of costs from rebates to the Medicare Trust Fund because of a change in classification of the benefits from supplemental benefits to basic benefits.

ⁱⁱⁱ Id at 15811.

^{iv} Id.

^v Id. at 15810- 158112.

^{vi} Connecticut General Assembly (CGA). 2015. Survey of states providing coverage for in-home telemonitoring services. Hartford, CT: CGA.

https://www.cga.ct.gov/hs/tfs/20151008_Medicaid%20Rates%20for%20Home%20Health%20Care%20Working%20Group/20151109/Survey%20of%20States%20Providing%20Coverage%20for%20Telemonitoring.pdf

vii Id.

viii Id.

ix Id.

x Id.

xi Id.

xii Id.

xiii http://www.iowaccc.com/wp-content/themes/iccc/pdf/Congestive_Heart_Failure.pdf

xiv <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4744872/pdf/tmj.2015.0206.pdf>