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TESTIMONY CONCERNING

HB 6838

AN ACT CONCERNING THE USE OF TELEMEDICINE TO PROMOTE EFFICIENCY IN THE
DELIVERY OF HEALTH CARE SERVICES

Before the Public Health Committee
January 31, 2007

Senator Handley, Representative Sayers and members of the Public Health Committee, my name is Brian Ellsworth and I am President & CEO of the Connecticut Association for Home Care, which serves over 75,000 elderly and disabled Connecticut citizens.

The Association **supports HB 6838**, which seeks to promote the use of telemedicine. This is a key part of the Association's 2007 legislative agenda. Over 20 percent of home health agencies in CT already provide telemonitoring services to a portion of their Medicare fee-for-service patients. Since the introduction of telemonitors in home care in the last decade, the technology has already significantly evolved to smaller, user-friendly devices that work through regular phone lines to send data to a remote location monitored by a clinician.

There are several key outcomes from home-based telemonitoring:

1. Unnecessary hospitalizations and emergency room visits can be avoided.
2. Home care visits can be reduced for some patients whose care can be successfully managed through these devices between visits.
3. Patients become more actively involved in the self-management of their own care.

So if this new technology is so great, why don't we have more of it?

The answer is simple: **the health care system has not figured out how to pay for it.**

For example, the federal Medicare program pays home health agencies a fixed fee for a period of home care. Within that fixed fee, home health agencies must do very careful internal cost benefit analysis to justify the implementation of telemonitors.

The shame of this limited, indirect financing approach is that it limits the dissemination of this technology while the Medicare program could be saving considerable expenditures for every avoided hospitalization and overall quality of care would be improved by minimizing acute flare-ups.

Unfortunately, the Medicaid program does not even have these limited, indirect incentives as Medicaid pays home health agencies by the visit and does not cover telemedicine.

To combat this, we would like to see direct grants to home health agencies for the leasing and operating costs of telemonitors for Medicaid patients. If targeted properly, it is likely that such grants would be self-financing through program savings. We **strongly support** the pilot language in Section 5 of the bill. This summer, we were privileged to work with the Department of Social Services on the submission of a Medicaid Transformation Grant to the Centers for Medicare & Medicaid Services (CMS) on a very similar program to what is proposed in the bill. Obviously, it would be great to get some extra federal dollars to pilot this program on a broader scale, but we still think it makes sense whether we get the federal grant or not.

Specific Comments on Sections 1 & 2 of HB 6838

Section 1. Informed Consent. The scope of the proposed language on informed consent procedures should be more limited. Telemonitoring just does not work without active patient involvement, so detailed procedures in statute are not necessary and could be counter-productive to the goals of this legislation. Federal and state privacy rules are also probably already sufficient to protect patient privacy.

Section 2. Service Definition and Payment by State Programs. This section appears to define telemedicine as a service when it substitutes for an otherwise eligible service. For home health care, we interpret this to mean that only if a telemonitoring device would substitute for otherwise eligible skilled nursing visits under a state program (e.g., Medicaid), it would be an eligible service for home health agencies. This definition is a good start, but it may be too narrow as some community-based state clients with chronic illnesses who are not under active care of a home health agency might still cost effectively benefit from telemonitoring services provided through an agency.

As far as payment goes, it should be based on the lease/depreciation cost of the unit and reasonable operating costs, including: installation, patient & staff training, remote monitoring by clinician, supplies and repairs. Specification of an inclusive process (payers, providers, consumers) for developing targeting criteria is the key to ensuring cost effectiveness on a large scale.

Thank you for consideration of our comments. I would be pleased to answer any questions you may have.