



November 17, 2015

*Submitted via the Federal eRulemaking Portal: <http://www.regulations.gov>*

Mr. Andrew Slavitt,  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: CMS-3321-NC**

Dear Mr. Slavitt:

The Alliance for Connected Care (the “Alliance”) appreciates the opportunity to respond to the *Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payment for Participation in Eligible Alternative Payment Models* (the “RFI”).<sup>1</sup>

The Alliance is a 501(c)(6) organization supporting policy that enables the use of evidence-based, safe, high-quality telemedicine and remote patient monitoring services. Our members are leading healthcare and technology companies from across the healthcare spectrum. The Alliance works in partnership with an Advisory Board that includes more than 20 patient and provider organizations.

As reflected in the comments below, the Alliance is committed to ensuring that Medicare beneficiaries and providers have greater access to connected care. In particular, our comments focus on the *Clinical Practice Improvement Activities Performance Category for the Merit-Based Incentives Program* and the establishment of bridge facilitating providers to transition to the payment era established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

**Inclusion of Telehealth and Remote Patient Monitoring in the Clinical Practice Improvement Activities Performance Category for the Merit-Based Incentives Program**

The RFI requests comment on activities that could be classified as clinical practice improvement activities under the Merit-Based Incentive Payment System (MIPS), as added by section 101(c) of MACRA.<sup>2</sup> Clinical practice improvement activities, a performance category under MIPS, are defined as “activities that

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<sup>1</sup> 80 Fed. Reg. 59102 (October 1, 2015).

<sup>2</sup> 42 U.S.C. 1305 note

relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, are likely to result in improved outcomes.” Section 101(c)(2)(B)(iii)(III) of MACRA lists, and the RFI reiterates, six subcategories: (1) Expanded practice access, (2) population management, (3) care coordination, “including use of remote monitoring or telehealth” (*emphasis added*), (4) beneficiary engagement, (5) patient safety and practice assessment, and (6) participation in an alternative payment model.

Telehealth and remote monitoring technologies empower the delivery of health care beyond the hospital or office setting and can help providers in meeting the goals of at least four categories of the MIPS program. MACRA listed telehealth and remote monitoring under the category of “care coordination,” but expanded practice access, population health management and beneficiary engagement can also be achieved. Below is evidence of how each of telehealth and remote monitoring contribute to achievement of higher performance in each of the categories:

### **1) Expanded Practice Access**

Telehealth facilitates the offering of same day appointments and after-hours access. Experience in the commercial market indicates that people use telemedicine when their physicians’ office is not open. One study that looked at 3,701 telemedicine visits by beneficiaries of the California Public Employees’ Retirement System (CalPERS) found that the timing of the telemedicine visits closely resembled the timing of ED visits.<sup>3</sup> An actuarial analysis of five of the top telemedicine vendors found that 36 percent of telemedicine visits happened on a weekday or holiday compared with eight percent of physician office visits. All of the telehealth platforms in the commercial market offer same- day telehealth appointments. Through use of telehealth by the provider practice or partnership with a telehealth provider, the requirements of “expanded practice access” can be met.

Remote patient monitoring also expands practice access. Today, if a patient with congestive heart failure suddenly gains weight, the patient is responsible for contacting the provider to schedule an appointment. The information is asymmetrical and the provider has to depend on patient self-reported data to determine the severity of the situation. With remote patient monitoring, the practice can immediately see the weight gain, make an assessment and reach out to the patient with instructions, thereby providing communication and access that is not possible without remote monitoring.

### **2) Population Health Management**

“Monitoring health conditions of individuals to provide timely health care interventions” is precisely what remote patient monitoring technology does. Devices that deliver patient psychological data remotely allow cost effective daily monitoring of vital signs and subjective symptoms to enable early detection of potential exacerbations, and thus emergency room visits and hospital stays.

Example 1: In 2013, Banner Health teamed with Royal Phillips to conduct a telehealth pilot program with in-home patients with multiple chronic conditions. The Intensive Ambulatory Care (IAC) pilot program targeted the highest cost and most complex patients— the top five percent of patients who account for 50 percent of health care spend. The results demonstrate the potential of applied

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<sup>3</sup> Lori Uscher-Pines and Ateev Mehrotra, 10.1377/hlthaff.2013.0989, *Health Affairs*. 33,NO. 2 (2014): 258–264

technologies for managing such patients. The program achieved a 27 percent reduction in cost of care, 32 percent reduction in acute and long term care costs, and 45 percent reduction in hospitalizations.<sup>4</sup>

Example 2: In 2012, Geisinger Health Plan (GHP) found that telehealth significantly reduced hospital readmissions and cost of care for members diagnosed with heart failure. The study showed that the odds of a patient being admitted to the hospital in any given month were 23 percent lower during the months when they were enrolled in the telemonitoring program; their odds of 30-day and 90-day readmissions were reduced 44 percent and 38 percent respectively. A total of 541 members— all GHP Medicare Advantage plan members, who were at least 65 years old with confirmed heart failure— were included in the final evaluation. They had a high prevalence of comorbid conditions (most commonly hypertension and coronary artery disease) and incurred a significant cost of care (average per-patient-per-month cost of ~\$1,600). The implementation of the telemonitoring program delivered an 11 percent cost savings during the study period, which is in addition to cost savings attributable to complex care management alone, the study found.<sup>5</sup>

### **3) Care Coordination**

Telehealth is instrumental in care coordination. Patients and health providers are empowered through telehealth as it enables immediate and meaningful communication on a patient's condition. This coordination of care has the result of improving the quality of care provided to a patient, improving the effectiveness of the provider's time, as well as proactively engaging the patient in the coordination process.

Example 1: To improve post-discharge outcomes for patients with chronic health conditions, the University of Virginia Health System (UVA) established a program where broadband remote monitors for blood pressure and oxygen saturation were installed in patient's homes post discharge to monitor vital signs. Patient data is monitored by nurses on a daily basis, encouraging proactive care response. UVA achieved a readmission rate of 10.4 percent in the 60 day period post discharge, which was 50 percent lower than the institution's historical trends.<sup>6</sup>

Example 2: In a 2011 Health Affairs study, researchers examined the impact of a care coordination approach called the Health Buddy Program, which integrates a telehealth tool with care management for chronically ill Medicare beneficiaries. They evaluated the program's impact on spending for patients of two clinics who were exposed to the intervention and compared their experience with that of matched controls. The findings show significant savings among patients who used the Health Buddy telehealth program, which was associated with spending reductions of approximately 7.7–13.3 percent (\$312–\$542) per person per quarter.<sup>7</sup>

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<sup>4</sup> Press release, "Banner Health achieves 27 percent cost savings through joint pilot telehealth program with Philips." May 4, 2015. Accessed at: <http://philips.to/1Qt8LOS>

<sup>5</sup> Daniel D. Maeng et al. "Can Telemonitoring Reduce Hospitalization and Cost of Care? A Health Plan's Experience in Managing Patients with Heart Failure." *Population Health Management*, 2014, Vol. 0, No. 0. DOI: 10.1089/pop.2013.0107. Available at: [http://www.amchealth.com/\\_files/published-outcomes/PopulationHealthManagement-GeisingerHFStudy-May2014.pdf](http://www.amchealth.com/_files/published-outcomes/PopulationHealthManagement-GeisingerHFStudy-May2014.pdf)

<sup>6</sup> See VHQC News. Available at: [http://broadaxecarecoordination.com/blog/UVA\\_HealthSystems\\_Article-1.pdf](http://broadaxecarecoordination.com/blog/UVA_HealthSystems_Article-1.pdf)

<sup>7</sup> Laurence C. Baker et al. "Integrated Telehealth and Care Management Program For Medicare Beneficiaries With Chronic Disease Linked To Savings." *Health Affairs*, September 2011, Vol. 30, No. 9: 1689-1697. doi:10.1377/hlthaff.2011.0216

Example 3: The Veterans Health Administration's (VHA's) national home telehealth program, Care Coordination/Home Telehealth (CCHT), aims to coordinate the care of veteran patients with chronic conditions and avoid their unnecessary admission to long-term institutional care. CCHT patients increased from 2,000 to 31,570 (1,500 percent growth) between 2003 and 2007. CCHT is now a routine non-institutional care (NIC) service provided by VHA to support veteran patients with chronic conditions as they age. Routine analysis of data obtained for quality and performance purposes from a cohort of 17,025 CCHT patients shows the benefits of a 25 percent reduction in numbers of bed days of care, 19 percent reduction in numbers of hospital admissions, and mean satisfaction score rating of 86 percent after enrollment into the program.<sup>8</sup>

#### **4) Beneficiary Engagement**

Telehealth and remote patient monitoring can be used by providers and patients to improve communication, education, and patient self-care.

Example 1: According to a study by Massachusetts General Hospital, using telehealth to deliver follow-up care to chronic disease patients improves patient satisfaction. Physicians involved in the remote consultations were similarly satisfied, reporting that the virtual meetings saved time, allowed for more continuous follow-up, and gave a better overall picture of the patient's wellbeing. The study examined the impact of online follow-up for patients with ten common diseases: hypertension, arthritis, diabetes, anxiety, depression, GERD, headaches, asthma, back pain, and weight control issues. After seeing a physician for one of these conditions, patients completed an online survey about their experience asking about improvements or declines in overall health as well as disease-specific questions to answer on a scale from zero, and were subsequently scheduled a video chat, phone call, or in-person consult as necessary.<sup>9</sup>

Example 2: Yet we respectfully suggest that existing Medicare coverage for telehealth is inadequate to meet the demands of a the modern health care system, due in part to CMS' interpretation of its statutory authority and restrictive reimbursement policies for telehealth under section 1834m of the Social Security Act.<sup>10</sup> By including remote patient monitoring as a clinical practice improvement activity, CMS is taking an important step to improving coverage. Currently, Medicare's definition of "interactive telecommunications systems" <sup>11</sup> does not include remote patient monitoring as a telehealth service.<sup>12</sup>

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<sup>8</sup> Darkins, Adam et al. "Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions." *Telemedicine and e-Health*. December 2008, Vol. 14, No. 10: 1118-1126.

<sup>9</sup> Dixon Ronald F. and Rao Latha. "Asynchronous Virtual Visits for the Follow-Up of Chronic Conditions." *Telemedicine and e-Health*. July 2014, Vol. 20, No. 7: 669-672.

<sup>10</sup> 42 U.S.C. 1395m

<sup>11</sup> In addition to the restrictions on telehealth services in 1834(m) of the Social Security Act, we note that "interactive telecommunications systems" are not defined in any relevant part of the Social Security Act. Rather, CMS chose to define "interactive telecommunications systems" in its 2001 Physician Fee Schedule final rulemaking to include at a minimum, audio and video equipment that hat permits real time consultation between the patient and physician, or practitioner at the distance site. *See* 66 Fed. Reg. 55, 281 (Nov. 11, 2000).

<sup>12</sup> *See* "CVS Health Research Institute Analysis Shows High Patient Satisfaction with MinuteClinic Telehealth Visits." August 18, 2015. Available at <http://www.cvshealth.com/content/cvs-health-research-institute-analysis-shows-high-patient-satisfaction-minuteclinic>

Despite these restrictions, evidence continues to demonstrate that remote patient monitoring is an increasingly important aspect of the health care delivery system, improving care, reducing hospitalizations, avoiding complications, and improving patient satisfaction.<sup>13</sup> Remote patient monitoring is especially critical to virtual chronic care management, as evidenced by the Department of Veterans Affairs' use of the technology, reporting a substantial decrease in hospital and emergency use.<sup>14</sup> Telemedicine tools, wireless communications systems, portable monitors, and cloud-based patient portals that provide access to health records are all up-and-coming technologies that are revolutionizing remote patient monitoring and the medical care industry, representing a market of over \$30 billion.<sup>15</sup>

Remote patient monitoring can collect a wide variety of health data, and transmit this data to health professionals for monitoring and treatment planning. Remote monitoring is especially valuable in older populations and those with chronic diseases, allowing these beneficiaries to avoid hospital stays and more effectively manage their conditions. Based on the existing body of evidence demonstrating the value of telehealth and remote patient monitoring, we urge CMS to include remote patient monitoring as a clinical practice improvement activity under the MIPS Program and to provide a menu of remote patient monitoring or consumer oriented information technology categories that primary care and specialties would use for care improvement, which include:

- Screening of patients with chronic conditions to determine if remote patient monitoring would provide benefit. Stratifying risk through data analytics should be used to identify patients most likely to benefit from RPM;
- Use of remote patient monitoring of biometric data for chronic condition management when screening determines it would be effective;
- Technology enabled health education based on condition management;
- Technology enabled communication for health coaching and health education; and,
- Electronic, two-way, communication between clinical staff and patient to support chronic conditions management.

### **A Bridge to MACRA**

As the provider community transitions to the new payment landscape, The Alliance is supportive of a narrowly targeted but meaningful proposal that lifts Medicare's outdated restrictions on the use of telemedicine, and reimburses for remote patient monitoring technology for patients with chronic conditions. The proposal, known as the "bridge," enables wider use of connected care technologies during a limited transition period as MACRA is implemented and ACOs work to achieve risk-based models.

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<sup>13</sup> See Hindricks, et al., *The Lancet*, Volume 384, Issue 9943, Pages 583 - 590, 16 August 2014 doi:10.1016/S0140-6736(14)61176-4. See also U.S. Agency for Healthcare Research and Quality (AHRQ) Service Delivery Innovation Profile, *Care Coordinators Remotely Monitor Chronically Ill Veterans via Messaging Device, Leading to Lower Inpatient Utilization and Costs* (last updated Feb. 6, 2013), available at <http://www.innovations.ahrq.gov/content.aspx?id=3006>.

<sup>14</sup> 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>.

<sup>15</sup> See Kalorama Information, *Advanced Remote Patient Monitoring Systems, 8th Edition* (2015), available at <http://www.kaloramainformation.com/redirect.asp?progid=87656&productid=9123949>.

Changing the health care system and provider practice is challenging, especially through large-scale, federally-driven mandates. The implementation of the Meaningful Use (MU) of electronic health records (EHRs) is one example. Expensive data infrastructure and confusing requirements created a burden and have resulted in frustration among providers. The scale and scope of MACRA is beyond that of MU and accordingly, successful implementation will hinge on adequate provider preparation and clinical resource investment. Providers and patients will need to explore approaches and technologies that can successfully support practice change. The ultimate goal is greater access to telemedicine services regardless of site or geography and greater adoption of remote patient monitoring technology. We believe there are ways to allow meaningful change in telemedicine and remote monitoring while also providing guardrails around the reimbursement that ensure the tools are being used to meet the goals of value-based care.

To that end, we have asked that CMS and CMMI create a transition mechanism by which the Secretary of Health and Human Services may lift originating site restrictions, and allow payment for remote monitoring of beneficiaries suffering from chronic diseases. We believe these reforms should remain in effect until at least the year 2021 as a bridge for providers who have committed to changing their practices to comply with MACRA or for ACOs working to achieve risk-based models. Such a transition period would facilitate preparation and serve as a glide path to a new era of value-based care.

### **Conclusion**

In closing, the Alliance appreciates the opportunity to provide comments regarding the transition to the new era of healthcare outlined in MACRA. We look forward to continuing to work with CMS to increase access to high quality connected care for Medicare beneficiaries. If you have additional questions, please do not hesitate to contact myself or Spencer Porr ([spencer.porr@connectwithcare.org](mailto:spencer.porr@connectwithcare.org) or 202.640.5941).

Sincerely,



Krista Drobac  
Executive Director  
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