



ALLIANCE *for*
CONNECTED CARE

September 8, 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-1631-P

Dear Mr. Slavitt:

The Alliance for Connected Care (the “Alliance”) appreciates the opportunity to respond to the *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 Propose Rule* (the “Proposed Rule”).¹

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 health care and technology companies from across the health care spectrum. The Alliance works in partnership with an Advisory Board that includes more than 20 patient and provider groups.

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 *Medicare List of Telehealth Services* and *Clinical Improvement Activities for the Merit-Based Incentives Program*.

Medicare List of Telehealth Services

The Proposed Rule updates the Medicare List of Telehealth Services by adding several CPT codes as Medicare telehealth services effective for CY 2016. The first set of codes relates to prolonged service in the inpatient or observation setting, to be billing in conjunction with hospital inpatient and skilled nursing facility evaluation & management (E/M) codes.

The second set of codes relates to end-stage renal disease (ESRD) related services for home dialysis patients, for children and adults. Specifically, CMS proposes to add payment for telemedicine to codes 90963, 90964, 90965, and 90966 related to ESRD counseling in a patient’s home, recognizing that “many components of these services would be furnished from an authorized originating site and, therefore, can be furnished via telehealth.”

¹ 80 Fed. Reg. 41686 (July 15, 2015).

The Alliance supports CMS' decision to add new codes to the Medicare List of Telehealth Services. We believe that in order to meet the demands of the modern 21st century health care system, CMS will need to use all available administrative authority and policy tools to allow provider use of health information technology.

As it relates to the ESRD-related services for home dialysis codes, the Alliance urges CMS to separate these services from the originating site requirement.² By maintaining that a beneficiary must be connected to an "authorized originating site," CMS is limiting the benefits of this newly added telehealth service to only beneficiaries residing in rural areas. Many beneficiaries residing in metropolitan and urban areas face their own unique set of barriers in accessing necessary health care services, as the shortage of health care providers extends beyond the rural setting. Roughly 80% of Medicare beneficiaries who live in the 1,200 metropolitan counties not included in the definition of 'rural' do not have coverage for telehealth services, including the codes newly added. We understand that there are limitations to CMS's authority in this area, but we urge CMS to reconsider the linkage of ESRD-related services for home dialysis to an authorized originating site.

Inclusion of Telehealth and Remote Patient Monitoring in Definition of Clinical Improvement Activities for Purposes of the MIPS Program

The Proposed Rule 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 the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.³ Clinical practice improvement activities, a performance category under MIPS, are defined as "activities that 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 Proposed Rule 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

² Under section 1834(m) of the Social Security Act (42 U.S.C. 1395m), Medicare reimburses for telehealth services provided to beneficiaries located at "originating sites" in rural Health Professional Shortage Areas (HPSAs) or counties outside of Metropolitan Statistical Areas (MSAs). "Originating sites" include physicians' offices, hospitals, skilled nursing facilities, rural health clinics, critical access hospitals (CAHs), federally qualified health centers, and community mental health centers.

³ 42 U.S.C. 1305 note

Employees' Retirement System (CalPERS) found that the timing of the telemedicine visits closely resembled the timing of ED visits.⁴ 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 CHF patient 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 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.

Citation: Press release, "Banner Health achieves 27 percent cost savings through joint pilot telehealth program with Philips." May 4, 2015

http://www.newscenter.philips.com/us_en/standard/news/press/2015/20150405_Philips_Telehealth.wpd#.VYRbbObjWhG

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. **Citation:** 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

⁴ Lori Uscher-Pines and Ateev Mehrotra, 10.1377/hlthaff.2013.0989, HEALTH AFFAIRS 33,NO. 2 (2014): 258–264

<http://www.amchealth.com/files/published-outcomes/PopulationHealthManagement-GeisingerHFStudy-May2014.pdf>

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% in the 60 day period post discharge, which was 50% lower than the institution's historical trends.

http://broadaxecarecoordination.com/blog/UVA_HealthSystems_Article-1.pdf

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. Citation: 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% 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% reduction in numbers of bed days of care, 19% reduction in numbers of hospital admissions, and mean satisfaction score rating of 86% after enrollment into the program. Citation: 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.

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. **Citation:** 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

Example 2: <http://www.cvshealth.com/content/cvs-health-research-institute-analysis-shows-high-patient-satisfaction-minuteclinic>

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.⁵ 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"⁶ does not include remote patient monitoring as a telehealth service.

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.⁷ 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.⁸ 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.⁹

⁵ 42 U.S.C. 1395m

⁶ 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).

⁷ 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>.

⁸ 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>.

⁹ See Kalorama Information, *Advanced Remote Patient Monitoring Systems, 8th Edition* (2015), available at <http://www.kaloramainformation.com/redirect.asp?progid=87656&productid=9123949>.

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.

Conclusion

In closing, the Alliance appreciates the opportunity to provide comments regarding the Proposed Rule. 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 us.

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac". The signature is written in a cursive, flowing style.

Krista Drobac
Executive Director
Alliance for Connected Care