



ALLIANCE *for*
CONNECTED CARE

September 2, 2014

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Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 (File Code CMS-1612-P)

Dear Administrator Tavenner:

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, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 Proposed Rule* (the “Proposed Rule”).¹

The Alliance is a 501(c)(6) organization that was formed to advocate for a statutory and regulatory environment in which every provider in America is permitted to deliver and be adequately compensated for providing safe, high-quality “Connected Care” at his or her discretion, regardless of care delivery location or technological modality. Our members are leading health care and technology companies from across the health care spectrum, representing insurers, retail pharmacies, telehealth platform providers, telecommunications companies, and health care entrepreneurs. The Alliance works in partnership with an Advisory Board that includes over 20 patient and provider groups.

“Connected Care” is the real-time, electronic communication between a patient and a provider, including telehealth, remote patient monitoring, and secure email communication between clinicians and their patients. As the Medicare program moves toward new care delivery models, such as accountable care organizations (“ACOs”) and bundled payment initiatives, Connected Care will play an increasingly important role in their success. From empowering Medicare beneficiaries and caregivers to become more engaged in their health care, to giving Medicare providers the technology to better coordinate care across settings, Connected Care can help improve care outcomes and generate savings to the program.

¹ 79 *Fed. Reg.* 40318 (July 11, 2014).

As reflected in the comments below, the Alliance is committed to ensuring that Medicare beneficiaries and providers have greater access to Connected Care to achieve these benefits. In particular, our comments focus on the new chronic care management services discussed in the Proposed Rule.

I. Comments on the New Chronic Care Management Services

Scope of Chronic Care Management Services

In the Proposed Rule, the Centers for Medicare & Medicaid Services (“CMS”) notes its commitment to primary care, highlighting a number of its primary care initiatives, including the Medicare Shared Savings Program, the Pioneer ACO Model, and the Primary Care Incentive Payment Program.² CMS acknowledges that care management services are a critical component of primary care, contributing to better health and reduced health care costs. Given the importance of care management services, in the CY 2014 Physician Fee Schedule, CMS finalized its policy to cover and separately pay for the provision of certain non face-to-face services for Medicare beneficiaries with two or more chronic conditions beginning in CY 2015. The two or more chronic conditions must be expected to last at least 1 year, or until the death of the beneficiary, and significantly put the beneficiary at risk of death, acute exacerbation/decompensation, or functional decline. While we recognize the newly created G code is intended to apply to beneficiaries with multiple conditions, it is important to note that we encourage CMS to modify the code description to include beneficiaries with even only one chronic condition. The benefits associated with chronic care management services are equally critical to beneficiaries with a single chronic disease and should not be limited to beneficiaries with multiple chronic conditions.

For the CY 2015 Proposed Rule, CMS reiterates the scope of services that will be reimbursed under the new code. The services include the following:³

- Access to care management services 24-hours-a-day, 7-days-a-week, which means providing beneficiaries with a means to make timely contact with health care providers in the practice to address the patient’s urgent chronic care needs regardless of the time of day or day of the week.
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Care management for chronic conditions including systematic assessment of patient’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

² *Id.* at 40364.

³ CMS also proposes to require that chronic care management services be furnished with an electronic health record (“EHR”) or other health IT or other health information exchange platform.

- Creation of a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues.
- Management of care transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after a beneficiary visit to an emergency department, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Coordination with home and community based clinical service providers as appropriate to support a beneficiary's psychosocial needs and functional deficits.
- Enhanced opportunities for a beneficiary and any relevant caregiver to communicate with the practitioner regarding the beneficiary's care through, not only telephone access, but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods.

CMS Has the Authority to Include Remote Patient Monitoring As A Chronic Care Management Service

Given that over two-thirds of Medicare beneficiaries suffer from more than one chronic condition, the Alliance commends CMS for its increasing focus on chronic care management services.⁴ In particular, we strongly support CMS' inclusion of "[e]nhanced opportunities for a beneficiary and any relevant caregiver to communicate with the practitioner regarding the beneficiary's care through, not only telephone access, but also through the use of secure messaging, internet or *other asynchronous non face-to-face consultation methods*."⁵ This language reflects CMS' clear authority to cover and reimburse for non face-to-face asynchronous services, such as remote patient monitoring.

Remote patient monitoring involves non face-to-face services that enable health care providers to communicate with their patients in the community (*e.g.*, a patient's home) and outside of costly health care settings. These services can include remote monitoring, evaluation, and management of a beneficiary's chronic condition through the use of technology that enables the secure, remote exchange of clinical data between the beneficiary and the treating provider. CMS has the authority to cover and reimburse for remote patient monitoring as Medicare Part B physicians' and nonphysician practitioner services.⁶

However, the current regulatory framework is a patchwork of coverage and reimbursement policies for certain remote patient monitoring services, including remote retinal imaging, implantable

⁴ CMS, *Chronic Conditions Among Medicare Beneficiaries: Chartbook – 2012 Edition*.

⁵ 79 *Fed. Reg.* 40318, 40368 (emphasis added)

⁶ 42 U.S.C. § 1395x(s).

device monitoring, and remote cardiac device monitoring. This approach has left a gap in the coverage and reimbursement of the routine monitoring of physiological and biometric data by remote patient monitoring technologies, which can ensure the continuity of care for Medicare seniors with chronic conditions. To the extent there is coverage and reimbursement for the collection and interpretation of such data, (*e.g.*, CPT code 99091), it is reimbursed in a piecemeal fashion or bundled with other services, if at all.

The creation of a unique G code for chronic care management services is intended to address this gap in coverage and reimbursement. Specifically, CMS acknowledges that this code for chronic care management is “designed to pay separately for non face-to-face care coordination services...”⁷ We strongly support establishing this code as it will rightfully reimburse Medicare providers for the time spent furnishing non face-to-face chronic care management services. As discussed below, non face-to-face services, which includes remote patient monitoring, are critical to better managing and controlling the costs of care for Medicare beneficiaries with chronic conditions. Reimbursing for these services will, therefore, become increasingly important as the Medicare program moves toward new care delivery and payment models (*e.g.*, ACOs and patient-centered medical homes) aimed at improving care coordination, while generating savings for the Medicare program. The right incentives, including new reimbursement frameworks, will be necessary to drive provider participation in these new models.

Accordingly, we urge CMS to make clear in the final rule that remote patient monitoring should be included in the scope of services provided under the new G code. In finalizing the code, we also encourage CMS, through appropriate guidance, to instruct its Medicare contractors and participating providers that remote patient monitoring is covered and reimbursed under the new code.

Remote Patient Monitoring Improves Health Care Outcomes and Reduces Costs

Despite limited Medicare coverage and reimbursement for remote patient monitoring to date, increasingly, these technologies and services are being utilized by providers and their patients and yielding positive results. As one example, St. Vincent Health – a member of Ascension Health and Indiana’s largest health care system – conducted a study to determine the impact of a remote care management program on patients with congestive heart failure (“CHF”) and chronic obstructive pulmonary disease (“COPD”) recently discharged from the hospital. During the 30-day follow-up period, the remote care management program included daily monitoring of patient biometrics (*e.g.*, blood pressure, body weight), interactive daily questionnaires, and video conferencing. Initial results showed a reduction in hospital readmissions to 5 percent as compared to 20 percent in the control group – a 75 percent reduction. Translated to the Medicare program, which spends an estimated \$26 billion on readmissions annually, of which over \$17 billion is preventable, this type of remote patient monitoring program has the potential to significantly reduce program costs, while improving beneficiary outcomes.⁸

⁷ 79 *Fed. Reg.* 40318, 40365.

⁸ The Robert Wood Johnson Foundation, “The Revolving Door: A Report on U.S. Hospital Readmissions - An Analysis of Medicare Data by the Dartmouth Atlas Project” (February 2013).

Additionally, home care providers and agencies are using remote patient monitoring to provide more proactive and timely care to their patients to help prevent costly interventions. Windsor Place Home Health in Windsor, Kansas, deployed telehomecare for its chronically ill Medicaid patients.⁹ In doing so, hospital readmissions, emergency room visits, and nursing home admissions were reduced to zero over a one year period. Total cost savings over the same time period was approximately \$1.3 million, while the per patient cost of the intervention was only \$6 per patient per day. Likewise, at Forrest General Home Care and Hospice in Mississippi, targeted telehomecare for patients with CHF and COPD caused hospitalization rates to drop from 20 percent to 3 percent and emergent care rates to fall from 7 percent to 2.5 percent over the course of a year.¹⁰

As illustrated by these examples, the benefit to care delivery and the savings that can be generated with the use of remote patient monitoring are evident. However, agency inaction has limited the ability for Medicare providers to fully utilize remote patient monitoring to care for chronically-ill beneficiaries. That is, without adequate reimbursement, many providers are unable to put forth the upfront costs to purchase remote patient monitoring technologies for their patients, despite the potential for long-term savings and improved outcomes. Therefore, again, we ask CMS to continue in the direction of the Proposed Rule and to make clear its intent to cover and reimburse for remote patient monitoring for Medicare beneficiaries as part of the new chronic care management code in the final rule.

II. 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.

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Sincerely,



Krista Drobac
Executive Director
Alliance for Connected Care

⁹ The National Association for Home Care & Hospice, Statement to the House Energy and Commerce Subcommittee on Health (May 21, 2014).

¹⁰ *Id.*