



ALLIANCE for  
CONNECTED CARE

September 8, 2015

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

Attn: Claire Schreiber, Gabriel Scott  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS–5516–P, P.O. Box 8013  
7500 Security Boulevard  
Baltimore, MD 21244–1850

**Re: Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services, CMS–5516–P**

The Alliance for Connected Care (the “Alliance”) appreciates the opportunity to respond to the *Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services Proposed Rule* (the “Proposed Rule”).

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.

We are encouraged that Centers for Medicare & Medicaid Services (CMS) is including telehealth and remote patient monitoring tools in your Comprehensive Care for Joint Replacement (“CCJR”) payment model. In brief, we support the steps that CMS has taken to remove existing restrictions on telehealth services in Medicare, and encourage CMS to take additional steps to remove other barriers by expanding the types of providers permitted to provide telemedicine services and add additional codes for reimbursement. We also strongly encourage the coverage of remote patient monitoring services in addition to telehealth.

#### **Waiver of Geographic Site Requirement and Originating Site Requirement**

Current Medicare rules narrowly define conditions around eligibility for coverage of telehealth services and restrict utilization of and reimbursement of telehealth in traditional Medicare fee-for-service (FFS). Under existing rules, Medicare beneficiaries in underserved urban areas and beneficiaries who are homebound outside of rural areas are unable to benefit from telehealth services, even though many of these beneficiaries living in metropolitan areas face barriers to accessing care.

We are pleased that CMS seeks to waive the geographic and originating site requirements of section 1834(m) of the Social Security Act. Allowing telehealth visits to originate in the beneficiary’s home, regardless of where the beneficiary lives, will expand providers’ ability to deliver timely follow up care.

Telehealth services in the beneficiary's home will increase communication between patient and provider, allowing for earlier identification and intervention of complications, and can enhance care coordination and efficiency.

### **Creation of New E/M Codes Specific to Telehealth Services**

The creation of a new set of HCPCS G-codes to more appropriately describe the evaluation and management (E/M) services provided to eligible beneficiaries in their homes via telehealth is highly necessary. We agree that the current E/M codes used to bill for telehealth do not adequately capture needed services in the beneficiary's place of residence. We also agree that the codes should have similar payment rates to office and outpatient E/M codes. We request that CMS make explicit that these codes are parallel to the codes developed on an annual basis as mandated by 1834(m).

Beyond E/M services, there is a need for rehabilitation codes to be included. Given the importance of rehabilitation in lower extremity replacement, rehabilitation codes should be allowed for the CCJR demonstration.

### **Additional Restrictions Necessary to Waive for Successful Model**

Follow up therapy is essential to recovery from lower extremity joint replacement. We urge CMS to waive limitations on payment for tele-rehabilitation services, i.e., physical therapy and occupational therapy. CMS should allow a CCJR provider to meet a patient's rehabilitative needs using telehealth where solutions exist to provide home-based video physical rehabilitation or sensor technologies used for tracking movement and muscle activation.

Similarly, we urge CMS to waive restrictions on more types of providers who may furnish telehealth services. Physical therapists and occupational therapists offer essential recovery services in lower extremity replacement surgery, yet these professionals are not permitted to provide telehealth services in the proposed rule. Follow up treatment for beneficiaries recovering from hip or knee replacement is not typically conducted by the beneficiary's surgeon or physician, rather, it is conducted by other health care professionals. For instance, activity and exercise are crucial to speed recovery, and such physical therapy might be overseen by a physical therapist, nurse, or physician's assistant. We urge CMS to consider broadening other health care professionals to include physical therapists and occupational therapists.

There is plenty of evidence that home rehabilitation services after joint replacement can lower costs. For example, the National Network of Telehealth Resource Centers conducted a [webinar](#) in January 2015 with the University of Sherbrooke in Quebec. They conducted a four-year controlled study on telehealth rehabilitation after knee replacement and found savings with no evidence of inferior quality.

### **Remote Patient Monitoring**

Remote patient monitoring (RPM), as described by the Alliance, is personal health and medical data transmitted from an eligible beneficiary in one location via electronic communications technologies and used by an eligible provider in a different location for the remote care, evaluation, and related support of the patient. RPM is not included in the 1834(m) definition of telemedicine and is not subject to 1834(m) restrictions. However, while there is significant evidence that RPM can reduce readmissions, ER visits and long-term care costs, reimbursement is minimal and variable.

RPM after surgery can significantly aid providers in early detection of complications and intervention. Reimbursement for RPM in the CCJR demo will be more than offset by cost savings. Evidence of RPM savings in Appendix A.

To aid providers in the use of RPM, we urge CMS to unbundle CPT code 99091, which has been given 1.59 RVUs but remains listed as a “bundled” code, meaning that there is no separate Medicare reimbursement for RPM because it is considered part of the content of service for other codes.

As you know, CMS recently determined that the reimbursement for chronic care management that had historically been included in E/M codes was insufficient. CMS created the chronic care codes that can be separately reimbursed. We urge CMS to change the “B” designation of the existing CPT code 99091, allowing separate payment (approximately \$57.00) to be made to CCJR providers for such services furnished within the episode of care.

#### **Data Monitoring**

We are pleased that CMS will be monitoring patterns of utilization. In addition, we urge CMS to extrapolate from the data cost savings resulting from the use of these technologies. We are confident savings will be demonstrated and we hope that CMS will quickly put the data into the public domain so discussion of the use of telemedicine among policy makers may be informed by Medicare data.

#### **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,



Krista Drobac  
Executive Director  
Alliance for Connected Care

## APPENDIX A

### Summary of Recent Evidence on Remote Monitoring and Telehealth (Not exhaustive)

#### Telehealth Evidence: Chronic Conditions

- 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](http://www.newscenter.philips.com/us_en/standard/news/press/2015/20150405_Philips_Telehealth.wpd#.VYRbbObjWhG)
- 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 <http://www.amchealth.com/files/published-outcomes/PopulationHealthManagement-GeisingerHFStudy-May2014.pdf>
- The University of Pittsburgh Medical Center (UMPC) has expanded its telemedicine program between 2012 and 2013, going from about 6,700 telemedicine patient visits in 2012 to about 10,000 in 2013. In this shift, they found that telemedicine helped drop hospital readmissions among patients with congestive heart failure to just 5 percent from 28 percent. **Citation:** Gregg, Helen. “UPMC Sees Improved Readmission Rates From Telemedicine.” Becker’s Health IT & CIO Review, May 29, 2014. <http://www.beckershospitalreview.com/healthcare-information-technology/upmc-sees-improved-readmission-rates-from-telemedicine.html>
- A study from the University of Rochester Medical Center that began in 2010 found that telemedicine helped eliminate one in five emergency room (ER) visits in a pool of 1,500 older adults in independent and assisted living. Also, 90 percent of the cases required no additional care by a primary care physician; and in 97 percent of the cases doctors, physician’s assistants, or nurse

practitioners were able to make a definitive diagnosis and treatment recommendation. **Citation:** University of Rochester Medical Center, "Is Telemedicine a Viable Alternative to Ambulance Ride and ER Visit?" June 11, 2015, <https://www.urmc.rochester.edu/research/blog/june-2015/is-telemedicine-a-viable-alternative-to-ambulance.aspx>

- 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
- 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 noninstitutional 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.
- 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
- A recent University of Michigan and University of Kentucky literature review found that telemedicine interventions for diabetes patients can help with glycemic control, reduce body weight, and increase exercise. Of particular note, the analysis included a three-year study of patients with Type 2 diabetes in Montana that showed telemedicine use for diabetes to be an "effective mode" of care for rural patients compared to more traditional care. Also part of the analysis, was a Tennessee study that found a 29 percent increase in patient adherence to

prescribed glycemic tests when nurses called patients to remind them to test themselves. **Citation:** Rashid L. Bashshur, et al. "The empirical evidence for the telemedicine intervention in diabetes management." *Telemedicine and e-Health*. May 2015, Vol. 21, No. 5: 669-672. doi: 10.1089/tmj.2015.0029.

- The findings of the literature review are proving true in health care settings across the country. 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 CHF and 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 Connected Care program could significantly reduce program costs, while improving beneficiary outcomes. **Citation:** 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).
- Telehomecare interventions for chronically ill Medicaid patients were deployed at Windsor Place Home Health in Windsor, Kansas. 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 just \$6 per patient per day. At Forrest General Home Care and Hospice in Mississippi, targeted telehomecare interventions 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. **Citation:** National Association for Home Care & Hospice, Statement submitted to the House Energy & Commerce Health Subcommittee, May 21, 2015. <http://docs.house.gov/meetings/IF/IF14/20140521/102250/HHRG-113-IF14-20140521-SD010.pdf>
- A recent University of Michigan and University of Kentucky literature review demonstrates the impact of telehealth on health care access, quality, and costs, focusing on three chronic diseases – congestive heart failure (“CHF”), stroke, and chronic obstructive pulmonary disease (“COPD”). Among CHF patients, telemonitoring was significantly associated with reductions in mortality ranging from 15 percent to 56 percent as compared to traditional care. Meanwhile, telestroke provides an advantage for stroke patients without readily available access to stroke specialists. The various modalities of telestroke have demonstrated the ability to reduce mortality in the range of 25 percent during the first year after the event. In addition, there is evidence to support the economic benefit of telemonitoring among CHF, stroke, and COPD patients, as measured by changes in hospital admission and readmission rates and cost-benefit analyses. **Citation:** Rashid L. Bashshur, et al. “The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management.” *Telemedicine and e-Health*. September 2014, Vol. 20, No. 9: 769-800 doi: 10.1089/tmj.2014.9981

- Remote patient monitoring technologies positively engage patients while helping to manage chronic and persistent disease states. For example, the Hackensack Alliance in New Jersey reduced readmission rates from 28% to 5% for congestive heart failure patients. Christus Health reduced the average cost for congestive heart failure readmissions from \$12,937 compared to \$1,231 per re-admission after implementing a remote patient monitoring system. **Citations:** Connected Health Case Study: Hackensack ACO - Remote Patient Monitoring for Chronic Disease. HIMSS, March 1, 2014. <http://www.himss.org/ResourceLibrary/genResourceDetailPDFReg.aspx?ItemNumber=29541> Connected Health Case Study: Christus Health - Improving Health at Home: Remote Patient Monitoring and Chronic Disease. HIMSS, September 17, 2013. <http://www.himss.org/ResourceLibrary/genResourceDetailPDFReg.aspx?ItemNumber=22361>
- Remote patient monitoring reduces health care use and improves quality of care in heart failure patients with implantable cardioverter-defibrillators (ICDs). A 2012 multicenter randomized trial involving 200 patients compared remote monitoring with standard patient management consisting of scheduled visits and patient response to audible ICD alerts. The primary end point was the rate of emergency department or urgent in-office visits for heart failure, arrhythmias, or ICD-related events. Over a 16-month period, such visits were 35% less frequent in the remote a **Citation:** Landolina M, et. Al. "Remote monitoring reduces healthcare use and improves quality of care in heart failure patients with implantable defibrillators: the evolution of management strategies of heart failure patients with implantable defibrillators (EVOLVO) study." 2012 Jun 19;125(24):2985-92. doi: 10.1161/CIRCULATIONAHA.111.088971. Epub 2012 May 24.
- The CONNECT (Clinical Evaluation of Remote Notification to Reduce Time to Clinical Decision) study was a multicenter, prospective, randomized evaluation involving 1,997 patients from 136 clinical sites who underwent insertion of an implantable cardioverter-defibrillator (including cardiac resynchronization therapy devices) and were followed up for 15 months. Health care utilization data included all cardiovascular-related hospitalizations, emergency department visits, and clinic office visits. The median time from clinical event to clinical decision per patient was reduced from 22 days in the in-office arm to 4.6 days in the remote arm. In addition, the health care utilization data showed a decrease in mean length of stay per cardiovascular hospitalization visit— 4.0 days in the in-office arm compared with 3.3 days in the remote arm. **Citation:** Crossley GH, et. Al. "The CONNECT (Clinical Evaluation of Remote Notification to Reduce Time to Clinical Decision) trial: the value of wireless remote monitoring with automatic clinician alerts". Journal of American College of Cardiology, 2011 Mar 8, Vol. 57, No. 10:1181-9.
- A study using 2009 data from 5,873 Medicare beneficiaries receiving home healthcare services through a network of community-based home health agencies operating in Texas and Louisiana found that patients in the telehealth group had a 7 percent lower probability of hospitalization within the first 30-day episode of home health care compared to those in the non-telehealth group. **Citation:** Hsueh-Fen Chen at el. "Telehealth and Hospitalizations for Medicare Home Healthcare Patients". American Journal of Managed Care, 2011 Jun 1, Vol. 17, No. 6.