Personal Connected Health Alliance
A collaboration between Continua, mHealth Summit and HIMSS

June 22, 2015

The Honorable Orrin Hatch
Chairman, Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
U.S. Senator
U.S. Senate
Washington, DC 20510

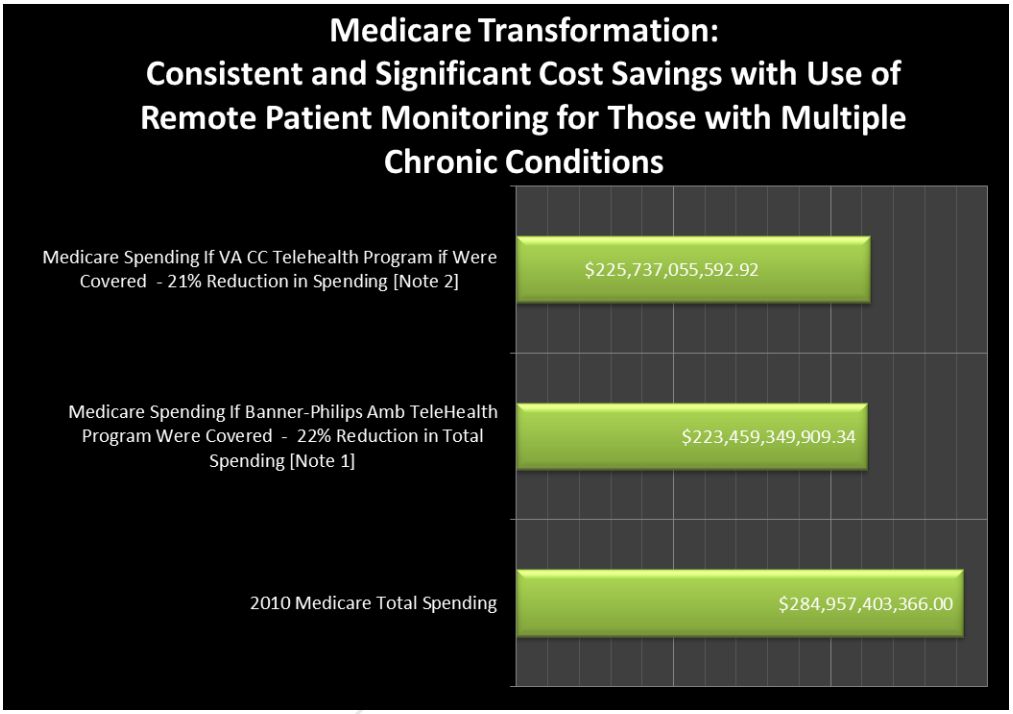
The Honorable Mark Warner
U.S. Senator
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

The Personal Connected Health Alliance (PCHA), formerly known as the Continua Health Alliance (Continua), is excited to have the opportunity to submit our ideas to transform and improve care provided to Medicare patients with chronic conditions. PCHA, through its over 150 Continua member companies, and its partnership with mHealth Summit and HIMSS, brings together expertise and resources focused on personalized connected health solutions that meet the needs of consumers throughout their lives. Our U.S. policy work focuses on promoting greater awareness, availability and access to plug-and-play, consumer-friendly personal health technologies to empower individuals to better manage their health and wellness, anywhere at any time. We offer the following ideas on transformation of care for Medicare patients with chronic conditions based on our expertise and work on health care innovation and development of disruptive technologies to improve care.

Digitally enabled healthcare delivery is transformative, providing patient-centered, individualized care in real time or near real time, leading to higher quality care that prevents complications and acute episodes that so often characterize the care trajectory of today's chronic condition patients. If it is covered and incorporated as part of a standard care delivery system for patients with chronic conditions, these delivery methods can positively transform the delivery of care and improve outcomes. Examples of this digitally enabled, patient-centered care delivery (such as remote patient monitoring coupled with care coordination) abound and if the results of these innovative delivery methods were applied to those in the Medicare program with multiple chronic conditions, the healthcare system could enjoy cost savings in excess of 20% through reduced acute illness episodes and disability.

The transformation demonstrated by both the Veterans' Administration (VA) and, more recently, through private sector pilots **consistently** demonstrate that bio-physical monitoring of vital signs (remote patient monitoring) in conjunction with care coordination, facilitated through information and communication technology (ICT), offers a transformed delivery of care that reduces acute illness episodes, reduces chronic disease complications, engages patients in self-care education, and is highly rated by patients (patients' satisfaction with care increases!).



Among the chronic condition patients for whom this eCare care coordination, bio-metric monitoring model has been tested and shown to improve care are those with:

- Multiple chronic conditions[i],[ii];
- Heart failure[iii],[iv],[v],[vi],[vii];
- Chronic Obstructive Pulmonary Disease[viii];
- Diabetes[ix]; and
- Chronic kidney disease.

The attributes of the care systems and pilots that transformed chronic care for patients all include the following:

- Electronic monitoring of identified bio-metrics for the relevant disease, such as daily weight, oxygen levels, glucose levels, etc.
- Daily review of bio-metric and patient generated data by care coordinator
- Daily health education messaging based on condition status
- A technology enabled method of communicating with a care coordinator, nurse, and/or physician upon request by the patient, 24/7 – phone, email, video, and/or audio.
- A technology enabled method to deliver new and updated care instructions based on the condition of the patient, 24/7 – phone, email, video, and/or audio.
- The interventions were successfully deployed and integrated into work streams by hospital clinics, ambulatory care centers, physician offices, and clinics as a combination of remote patient monitoring and care coordination.

Despite extensive clinical evidence and clinical trial research demonstrating the need, patient satisfaction, care improvement, and feasibility of a digitally enabled new care delivery model for those with chronic conditions, Medicare, even in its innovation pilots and other modernization initiatives, restricts use of clinically proven remote monitoring and care coordination. The Medicare program established as an acute care insurance system covering only services delivered in person or "face-to-face" in licensed health care facilities is the primary obstacle to positive transformation of care delivery to patients with chronic conditions. For example:

- **Fee for Service (FFS) Medicare impedes use of innovative disruptive technology**, such as remote patient monitoring for patients with chronic diseases, by paying only for face-to-face encounters. The new chronic care management (CCM) code -- which is a step toward better care -- covers only a sliver of the non-face-to-face services demonstrated to be effective and needed. The FFS system and the future Merit-Based Incentive Payment System (MIPS) rely on a physician visit, face-to-face care model rather than a more efficient model of care that engages the physician as needed, provides care updates in near real time based on near real time patient data, and enables care where patients live and work.
- **Accountable Care Organizations can't implement this positive disruptive technology and approach to care, because they are tied to FFS rules for payment and care delivery**. Most recently, CMS declined to implement waivers of the Section 1834(m) telehealth rules for the existing ACOs though the agency indicated they would consider waivers for the newest model just being implemented.
- **Medicare Part C, or Medicare Advantage, tied to the FFS benefits and rules of operation, is inhibited from deploying this positive care delivery disruptor**. Medicare Advantage plans may only offer telehealth services as a supplemental benefit, i.e. it cannot be offered as a basic benefit. This approach seriously limits the ability of Medicare Advantage plans to incorporate remote patient monitoring into benefit design.

- **Initiatives to transform Primary Care through Innovation Center pilots are tied to FFS reimbursement** rules, rely extensively on physician delivery of care (rather than through an extender model of care), and are of limited scope.
- **Hospital Care Quality Improvement i.e. reducing readmissions** focuses on those in the hospital and for 30 days post-discharge. This initiative did lead to some use of ICT delivered care coordination and monitoring, and data shows that it helps to substantially reduce readmission rates. However, the equipment and monitoring ends at 30 days post hospital discharge, even for those patients for whom it would be beneficial on a longer term basis.
- **Dual eligible care faces substantial hurdles to disruptive innovation** as it is stymied by the federal state partnership, which brings both the Medicare FFS restrictions on top of a variety of state laws.

Transformation of care provided to Medicare beneficiaries with chronic disease is desperately needed. The current approach to pilots through ACOs, bundled payment pilots, and hospital quality improvement incentives all retain the fee-for-service and face-to-face, facility-based bias that impedes adoption and implementation of transformational chronic care delivery. To address these problems, Congressional action will be needed. We recommend that the Chronic Care Working Group develop legislative proposals to either 'go big' and implement a system-wide transformation, or 'go incremental' and establish a real path for slow uptake and adoption of care coordinated remote patient monitoring for Medicare beneficiaries with chronic conditions.

'Go Big': Transforming Care for Medicare Patients with Chronic Conditions

1) Establish a care coordination health technology benefit for all beneficiaries with 2 or more chronic conditions, focused on higher cost chronic condition dyads, and can be provided to a patient by any provider or entity that agrees to coordinate/link with beneficiaries' physicians and care professionals.
    - ✓ Can be implemented by requiring reimbursement of current remote patient monitoring CPT code(s) along with the chronic care management fee, i.e. billing and reimbursement for both codes.
    - ✓ Can be limited to those with multiple chronic conditions, like the chronic care management code.
2) Establish a care coordination health technology benefit for beneficiaries with heart failure, COPD, stroke, or chronic kidney failure; can be offered by any provider/entity who agrees to coordinate/link with beneficiaries' physicians and care professionals.
    - ✓ Can be implemented by requiring reimbursement of current remote patient monitoring CPT code(s) along with the chronic care management fee, i.e. billing and reimbursement for both codes.

'Go Incremental: Incremental Paths to Provide Improved Care Delivery to Medicare Patients with Chronic Conditions

1) Modify the Physician Fee Schedule to permit billing for remote monitoring/review of bio-physical in addition to CCM for patients hospitalized in the last 6 months who also have 2 or more chronic conditions.
2) Grant authority to the Secretary to waive Section 1834(m) restrictions on telehealth for Medicare Advantage plans upon request in an annual bid.
3) Lift all 1834(m) telehealth restrictions (geographic, originating site, and real-time/video) for Medicare patients with heart failure, COPD in addition to another chronic condition.

Please contact me if you need any additional information or have questions. PCHA welcomes the opportunity to work with the Chronic Care Working Group as it considers these and other exciting policy changes that can improve and transform our nation's care of Medicare beneficiaries with chronic conditions.

Sincerely,

Rob Havasy
Vice President, Personal Connected Health Alliance
Executive Director, Continua Health Alliance

[i] Darkins A, Ryan P, Kobb R, Foster L, Edmonson E, Wakefield B, Lancaster AEs, Telemed J E Health. 2008 Dec;14(10):1118-26. doi: 10.1089/tmj.2008.0021

[ii] http://www.pharmiweb.com/pressreleases/pressrel.asp?ROW_ID=114155#.

[iii] Telemonitoring or structured telephone support programmes for patients with chronic heart failure: systematic review and meta-analysis, Robyn Clark, Sally Inglis, Finlay McAlister, John Cleland, Simon Stewart, MJ (British Medical Journal), doi:10.1136/bmj.39156.536968.55

[iv] J Am Coll Cardio: 2009;54:1683-94

[v] University of Ottawa Heart Institute, Feburary 24, 2011, Press Release

[vi] St. Vincent's Hospital Reduces Readmissions by 75 percent with a Remote Patient Monitoring-Enabled Program, Case Study by Care Innovations, an Intel GE Company

[vii] Broderick, Andrew; *Partners HealthCare: Connecting Heart Failure Patients to Providers Through Remote Monitoring,* The Commonwealth Fund, Publication 1657 Vol 3

[viii] Broderick, Andrew *The Veterans Health Administration: Taking Home Telehealth Services to Scale Nationally,* The Commonwealth Fund, Publication 1657 Vol. 4

[ix] Cluster-Randomized Trial of a Mobile Phone Personalized Behavioral Intervention for Blood Glucose Control, Charlene Quinn, Michelle Shardelll, Michael Terrin, Eric Barr, Soshana Ballew, Ann Gruber-Baldini, Diabetes Care. Published Online July 25, 2011