



TELECOMMUNICATIONS
INDUSTRY ASSOCIATION

1320 N. Courthouse Rd., Suite 200
Arlington, VA 22201 USA
www.tiaonline.org

Tel: +1.703.907.7700
Fax: +1.703.907.7727

Submitted via AdvanceNotice2015@cms.hhs.gov

March 7, 2014

The Honorable Marilyn Tavenner
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: Comments of the Telecommunications Industry Association to the Centers for Medicare & Medicaid Services on its *Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter*

Dear Administrator Tavenner:

The Telecommunications Industry Association (“TIA”) writes to submit input to the Centers for Medicare & Medicaid Services (“CMS”) on its *Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter*.¹ Specifically, TIA submits comments below on “Part C Services Via Remote Access Technologies,”² and encourages CMS to utilize any means in Medicare Part C available towards realizing the potential of remote access technologies such as remote patient monitoring solutions. Although CMS is currently limited by statutory definitions for telehealth services, CMS should allow Medicare Advantage Organizations (“MAOs”) to use

¹ CMS, *Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter* (Feb. 21, 2014) (“CMS Proposal”), available at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2015.pdf>.

² See CMS Proposal at pgs. 111-112.

such technologies in contract year (CY) 2015 as mandatory supplemental benefits, and where possible expand upon those benefits. We strongly believe that including remote monitoring solutions as a mandatory supplemental benefit will serve as a significant step towards modernizing the delivery of care by extending beyond the walls of the hospital room

I. Introduction and Statement of Interest

TIA is a trade association representing hundreds of information and communications technology (“ICT”) manufacturers and vendors, and houses industry policy efforts specific to healthcare ICT and enhancing eCare.³ TIA members are long-time supporters of enhanced telehealth and remote monitoring services and we believe that remote connectivity has become an essential part of 21st century medical care.

Telehealth services enable the transmitting of vital signs as part of care plans for chronic disease patients; electronic health records (“EHRs”); the transmission of important medical device data, text and images for specialist diagnoses such as X-rays, MRIs, and CAT scans; video conferencing for telemedicine or training; and even timely access to emergency medical providers to save lives. These benefits are especially important for rural areas where telemedicine consultations with specialists such as pediatric critical-care physicians have been shown to improve the quality of care for seriously ill and injured children treated in rural emergency rooms.⁴ In addition to benefits most directly enhanced by telehealth services, there are other residual benefits to our society by decreasing the cost of the American healthcare system. For example, remote patient monitoring – just one aspect of telehealth services – is expected to save \$36 billion globally by 2018, with North America accounting for slightly more than three-quarters of these savings.⁵

³ For more on these and other associated TIA policy efforts, see <http://tiaonline.org/policy>.

⁴ See, e.g., Dharmar, et al, Impact of of Critical Care Telemedicine Consultations on Children in Rural Emergency Departments, *Journal of Critical Care Medicine* (Aug, 7, 2013), doi: 10.1097/CCM.0b013e31828e9824.

⁵ See Juniper Research, *Mobile Health & Fitness: Monitoring, App-enabled Devices & Cost Savings 2013-2018* (rel. Jul. 17, 2013), available at http://www.juniperresearch.com/reports/mobile_health_fitness.

II. TIA Comments Specific to the CMS Proposal

a. TIA Supports CMS Permitting Medicare Advantage Organizations to Provide Remote Monitoring Technologies as a Mandatory Supplemental Benefit.

The CMS Proposal would allow for MAOs to provide remote monitoring technologies as a mandatory supplemental benefits – these being “Telemonitoring, and Web- and Phone-based Technologies, Nurse Hotline,’ and other similar services.” TIA agrees with this proposal from CMS.⁶

Growing bodies of clinical evidence suggest that interoperable remote monitoring improves care, reduces hospitalizations, helps avoid complications, and improves satisfaction, particularly for the chronically ill.⁷ Patient-generated health data that is captured through remote monitoring solutions can enhance patient care and raise accountability by healthcare providers,⁸ as well as engage patients in their own care, leading to improved lifestyle choices and improve overall health.⁹ Further, it is important for CMS to provide MAOs with the certainty that, in their use of remote monitoring solutions, all enrollees be covered when clinically indicated and appropriate. TIA therefore supports the CMS proposal to permit MAOs to provide remote monitoring technologies as a mandatory supplemental benefit. Furthermore, TIA urges CMS to extend this policy to all Medicare beneficiaries without additional premium payments, including all Part A and Part B benefits. Such a decision would be consistent with other subtle but important recent proposals that CMS has issued signaling the agency’s interest

⁶ CMS Proposal at 111.

⁷ See, e.g., 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 NeHC, *Patient Generated Health Data Introduction and Current Practices: Report to the HIT Policy Committee Consumer Empowerment Workgroup by the Technical Expert Panel Convened by National eHealth Collaborative on behalf of the Office of the National Coordinator for Health Information Technology* (Jul. 18, 2013), available at <http://www.nationalehealth.org/blog/patient-generated-health-data-technical-expert-panel-presents-initial-findings>.

⁹ See, e.g., Sanjena Sathian, “The New 21st Century House Call,” *Boston Globe* (July 29, 2013), available at <http://www.bostonglobe.com/lifestyle/health-wellness/2013/07/28/century-house-call/tdupWvOQI6b3dKdKcEgdGM/story.html>.

to explore innovative technological healthcare delivery mechanisms. The addition of Transitional Care Management Codes in the 2013 Physician Fee Schedule, to the most recent proposal in the 2014 Physician Fee Schedule for an expansion of coverage to non-face-to-face complex care management services for Medicare beneficiaries who have two or more significant chronic conditions, both offer the opportunity for providers to choose innovative technological solutions.

b. CMS Should Maintain Network Access Requirements for the Initial Implementation of Remote Monitoring Technology

In the CMS Proposal, comments are sought on an approach to implement authority over mandatory supplemental benefits and access requirements, which would require that “MA plans’ networks must continue to meet [CMS] access standards; any remote access technologies would be in addition to, not a replacement of, an adequate provider network.”¹⁰ TIA believes that by continuing main network access requirements for remote monitoring solutions during the first year of implementation, CMS can prevent these solutions from degrading network transmission quality. However, we urge CMS to approach this requirement nimbly so that it does not impede the innovation at a later time when the quality of transmissions may find a better solution for ensuring access. Therefore, TIA urges that, once demonstrated by clinical data that remote monitoring technology provides satisfactory transmission quality, CMS should re-examine the necessity of the main network access requirement.

c. Several Current Care Delivery Programs, and a Large Body of Research, can Helpfully Inform CMS’ Approach

In the CMS notice, proposals or descriptions of current care delivery programs that may help CMS establish standards for such approaches are solicited.¹¹ TIA believes that an informed approach by CMS in this matter can be guided by several existing programs which were created

¹⁰ CMS Proposal at 111.

¹¹ CMS Proposal at 112.

to explore alternative payment solutions including technological advancements such as the use of remote monitoring solutions. CMS should consider:

- The CMS Innovation Center’s (“CMMI”) Independence at Home pilot program,¹² which is using remote monitoring and mobile diagnostic technologies;
- The CMMI’s Comprehensive ESRD Care initiative,¹³ which will very likely examine the benefits of remote monitoring to those suffering from end stage renal disease (“ESRD”); and
- The Veteran’s Administration Home Based Primary Care program,¹⁴ which has comprehensively shown an improvement in quality of care, as well as cost reductions, for patients with multiple chronic conditions.

Furthermore, TIA notes that there are extensive clinical studies for CMS to consult, including in the areas of: chronic condition management; heart failure management; diabetes management and medication adherence for chronic conditions meet stringent review standards and demonstrate strongly the benefits of non-synchronous telehealth and remote patient monitoring. Below, we list examples of clinical trials under each of these categories for CMS’ consideration:

CHRONIC CONDITION MANAGEMENT

Veterans Administration: Study Size: Over 17,000 patients.

“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 enrolment into the program. The cost of CCHT is \$1,600 per patient per annum, substantially less than other NIC programs and nursing home care. VHA’s experience is that an enterprise-wide home telehealth implementation is an appropriate and cost-effective way of managing chronic care patients in both urban and rural settings.” “Care Coordination/Home Telehealth: the systematic implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic condition” [Darkins A, Ryan P, Kobb R, Foster L, Edmonson

¹² See <http://innovation.cms.gov/initiatives/independence-at-home/>.

¹³ See <http://innovation.cms.gov/initiatives/comprehensive-ESRD-care/>.

¹⁴ See http://www.va.gov/geriatrics/guide/longtermcare/home_based_primary_care.asp.

E, Wakefield B, Lancaster AEs, Telemed J E Health. 2008 Dec;14(10):1118-26. doi: 10.1089/tmj.2008.0021.] <http://online.liebertpub.com/doi/pdf/10.1089/tmj.2008.0021>

Primary Care E-Visit v. Physician Office Visit: Study Size 8,000 Office and E-Visits

From The Washington Post, 1/21/2013: “A new study suggests that “e-visits” to health-care providers for sinus infections and urinary tract infections (UTIs) may be cheaper than in-person office visits and similarly effective.” [Ateev Mehrotra, MD; Suzanne Paone, DHA; G. Daniel Martich, MD; Steven M. Albert, PhD; Grant J. Shevchik, MD, JAMA Intern Med. 2013;173(1):72-74. doi: 10.1001/2013. jamainternmed.305] <http://archinte.jamanetwork.com/article.aspx?articleid=1392490>

Randomized Control Trial of Telehealth and Telecare: Study Size 6,191 patients, 238 GP practices

“The early indications show that if used correctly telehealth can deliver a 15% reduction in A&E visits, a 20% reduction in emergency admissions, a 14% reduction in elective admissions, a 14% reduction in bed days and an 8% reduction in tariff costs. More strikingly they also demonstrate a 45% reduction in mortality rates.” [Source: “Whole System Demonstrator Programme, Headline Findings – December 2011”, Department of Health, United Kingdom] <http://www.telecare.org.uk/sites/default/files/file-directory/secure%20annual%20reports/Publications/Effect%20of%20Telehealth%20on%20use%20of%20secondary%20care%20and%20mortality%20findings%20from%20the%20WSD%20cluster%20randomised%20trial.pdf>

HEART FAILURE MANAGEMENT

Remote Patient Monitoring of Heart Failure Patients, Meta analysis: Study Size 4,264 patients

“Remote monitoring programmes reduced rates of admission to hospital for chronic heart failure by 21% (95% confidence interval 11% to 31%) and all cause mortality by 20% (8% to 31%); of the six trials evaluating health related quality of life three reported significant benefits with remote monitoring.” [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 (published 10 April 2007)] <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1865411/>

Remote Patient Monitoring of Heart Failure Patients, Meta analysis: Study Size 6,258/2,354 Patients

“RPM confers a significant protective clinical effect in patients with chronic HF compared with usual care.” [J Am Coll Cardio: 2009;54:1683-94] <http://content.onlinejacc.org/article.aspx?articleid=1140154>

Telehome Monitoring Program: 1,000 Patients Enrolled

“Research at the Heart Institute has shown telehome monitoring at the Heart Institute has cut hospital readmission for heart failure by 54 percent with savings up to \$20,000 for each patient safely diverted from an emergency department visit, readmission and hospital stay.” [University of Ottawa Heart Institute, February 24, 2011, Press Release] [http://www.heartandlung.org/article/S0147-9563\(07\)00084-2/fulltext](http://www.heartandlung.org/article/S0147-9563(07)00084-2/fulltext)

Remote Patient Monitoring at St. Vincent’s Hospital:

“Impact: In less than two years, preliminary results show that the care management program implemented by St. Vincent Health and facilitated by the Guide platform reduced hospital readmissions to 5 percent for patients participating in the program – a 75 percent reduction compared to the control group (20 percent), and to the national average (20 percent).” [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] http://www.careinnovations.com/data/sites/1/downloads/Guide_product/guide_stvinc ent_profile.pdf

DIABETES MANAGEMENT:

Mobile Phone Personalized Behavior Coaching for Diabetes: Study Size 163 patients over 26 Practices

“Conclusions – The combination of behavioral mobile coaching with blood glucose data, lifestyle behaviors, and patient self-management individually analyzed and presented with evidence-based guidelines to providers substantially reduced glycated hemoglobin level over 1 year.” [Cluster-Randomized Trial of a Mobile Phone Personalized Behavioral Intervention for Blood Glucose Control, Charlene Quinn, Michelle Shardell, Michael Terrin, Eric Barr, Soshana Ballew, Ann Gruber-Baldini, Diabetes Care. Published Online July 25, 2011] <http://care.diabetesjournals.org/content/34/9/1934.long>

Mobile Phone Diabetes Management: Study Size 30 patients from 3 group practices

“Conclusions: Adults with type 2 diabetes using WellDoc’s software achieved statistically significant improvements in A1c. HCP and patient satisfaction with the system was clinically and statistically significant.” [WellDoc™ Mobile Diabetes Management Randomized Controlled Trial: Change in Clinical and Behavioral Outcomes and Patient and Physician Satisfaction, Charlene Quinn, Suzanne Sysko Clough, James Minor, Dan Lender, Maria Okafor, Ann Gruber-Baldini, Diabetes Technology & Therapeutics, Vol 10, Number 3, 2008, pps 160-168] <http://online.liebertpub.com/doi/pdf/10.1089/dia.2008.0283>

MEDICATION ADHERENCE FOR CHRONIC CONDITIONS: 50 patients

“There was a trend toward increased prescription refill rates with the use of the Pill Phone application and a decrease after the application was discontinued” [Case study

titled: "Medication Adherence and mHealth: The George Washington University and Wireless Reach Pill Phone Study", Study designed, conducted and analyzed by George Washington University Medical Center; Qualcomm Wireless Reach Initiative was the primary funder of this study]

<http://www.qualcomm.com/media/documents/files/wireless-reach-case-study-united-states-pill-phone-english-.pdf>

III. Conclusion

TIA appreciates the careful consideration of its views in this matter by CMS, and urges you to contact the undersigned with any concerns or questions.

Respectfully submitted,

TELECOMMUNICATIONS INDUSTRY ASSOCIATION

By: /s/ Danielle Coffey

Danielle Coffey

Vice President, Government Affairs

Brian Scarpelli

Senior Manager, Government Affairs

TELECOMMUNICATIONS INDUSTRY ASSOCIATION

1320 North Courthouse Road

Suite 200

Arlington, VA 22201

703.907.7700

March 7, 2014