PHILIPS

February 6, 2015

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-1461-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1813

Re: Medicare Program; Proposed Rule on Medicare Shared Savings Program: Accountable Care Organizations

Dear Administrator Tavenner:

On behalf of Philips Health Systems (Philips), I am pleased to have this opportunity to comment on the Proposed Rule. Philips provides solutions that span the health continuum, including imaging, patient monitoring, and cardiac care systems; medical alert systems; sleep management and respiratory solutions; healthcare informatics solutions and services; and, pertinent to the proposed rule, a complete range of comprehensive telehealth programs.

Philips supports efforts to reform the health care delivery system to facilitate the provision of high quality, cost effective health care services to Medicare beneficiaries and other patients. Overall, we support the regulatory revisions and program policy modifications in the rule that are intended to reduce the burden associated with the infrastructure, start-up and ongoing annual operating costs for SSP ACOs (e.g. simplifying the application process for certain ACOs with experience under the Pioneer ACO Model and streamlining sharing of beneficiary data). More specifically, we appreciate CMS' recognition of the role that telehealth can and should play in achieving the goals of the ACO program, and note that the Proposed Rule includes a number of provisions that focus on the potential for telehealth to improve access and quality, and reduce costs.

The Role of Telehealth in Achieving Cost Savings and Quality Improvement.

In the Proposed Rule, CMS notes that ACOs have flexibility to use telehealth services as they deem appropriate for their efforts to improve care and avoid unnecessary costs and that some ACOs already have reported that they are actively using telehealth services to improve care for their beneficiaries. Accordingly, the Proposed Rule solicits additional information from ACOs and others about the use of such technologies.

Philips' believes that coordinated telehealth programs are the only cost-effective solution to systematically manage patient populations with ongoing needs, particularly those with medically complex and/or chronic conditions. Several hospital systems are adopting these programs including Mercy (St. Louis, Missouri); Banner Health (Phoenix, Arizona); and Avera (Sioux Falls, South Dakota) and are implementing system-wide telehealth programs. Philips' telehealth programs are designed to enable providers to coordinate care across the continuum for patients ranging from those who require chronic management to patients with complex, high-risk conditions requiring acute intervention. These programs include:

- **Remote Intensive Care Program (eICU)** – A comprehensive technology and clinical reengineering program that enables health care professionals from a centralized telehealth center to providing around-the-clock care for critically ill patients. With critical care costs in the U.S. total roughly $80-$100 billion per year, research

published in the December, 2013 issue of CHEST Journal's **Online First** (*"A Multi-Center Study of ICU Telemedicine Reengineering of Adult Critical Care," Craig M. Lily, M.D., Professor of Medicine, Anesthesiology and Surgery at the University of Massachusetts and Director of the eICU Program at UMass Memorial Medical Center*) examined the impact of Philips' eICU program on nearly 120,000 critical care patients across 56 intensive care units (ICUs), 32 hospitals and 19 health systems over a five-year period. The study demonstrated substantial reductions in mortality and length of stay. In fact, patients were discharged from the ICU 20% faster and discharged from the hospital 15% sooner than patients not monitored under an eICU program.

- **eAcute Program** – Modeled after the eICU, this program monitors high-risk hospitalized patients on medical-surgical floors to prevent avoidable complications. Results of the eAcute pilots have shown a 17% reduction in cost/case, a 36% reduction in falls, and a 17% reduction in average length of stay.

- **Bedside Skilled Nursing Facility (SNF) Program**: This program provides remote management services and emergency department (ED) consults for telestroke, telepsych and trauma triage. Early results show a 25-30% reduction in emergency department transfers.

- **High Risk Ambulatory Care (eIAC program)** – This program manages high-risk patients with multiple chronic conditions in the home. To date, there has been a 33% reduction in admissions of Medicare patients with multiple chronic conditions enrolled in the eIAC program at Banner.

- **Remote monitoring programs for daily management of patients with chronic conditions** - The most recent and largest study, titled "The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management," was published in *TELEMEDICINE and e-HEALTH* in September, 2014. It was authored by 23 experts in the area of Telemedicine, including 13 MDs and 6 PhDs. The paper reviewed the use of telemedicine for the remote care of patients in the home for CHF, COPD, and stroke. The paper reviewed 13 years of literature. It reviewed 1,529 publications, and selected 71 studies in total that met its criteria for inclusion in the analysis. Experts concluded that "the preponderance of the evidence produced by telemonitoring studies points to significant trends in reducing hospitalization and emergency department visits and preventing and/or limiting illness severity and episodes, resulting in improved health outcomes." Additionally, the economic effects of telemonitoring were measured or examined in two ways: (1) changes in rates or volumes of hospital admissions, re-admissions, length of stay, and/or emergency department visits and (2) cost-benefit analysis and cost-effectiveness analysis of telemonitoring in terms of specified outcomes. In both instances and with few exceptions, the evidence supported the economic benefits of telemonitoring compared with usual care among patients with CHF, stroke, and COPD.

Philips' Comments on Telehealth Proposals in the Proposed Rule.

Proposed ACO Application Requirements. The Proposed Rule would require an ACO to describe in its application how it will encourage and promote the use of enabling technologies for improving care coordination, including telehealth services; to add a new provision to require an ACO applicant to describe how the ACO intends to partner with long-term and post-acute care providers to improve care coordination for the ACO's assigned beneficiaries; and to add a provision to require that an ACO define and submit major milestones or performance targets it will use, which may include e-care plan tools for virtual care teams.

Philips Comments: Philips strongly supports the inclusion of these new requirements in ACO applications, and urges CMS to incorporate these requirements in applications by approved ACOs for contract renewal.

Proposed Data Availability Revisions. CMS proposes to expand the information made available to ACOs to include certain additional beneficiary identifiable data, including demographic data; health status information such as risk profile, and chronic condition subgroup; utilization rates of Medicare services; and expenditure information related to utilization of services.

Philips Comments: Philips strongly supports this proposal. Access to certain beneficiary identifiable data is essential when taking risk for a population's health, particularly to differentiate between beneficiaries who may have more complex needs and those who may only need an annual check-up. We encourage CMS to finalize data sharing policies and procedures that enable ACOs to better identify Medicare beneficiaries who would benefit from ongoing care.

Proposed Definition of Primary Care Services. CMS proposes to add transitional care management and chronic care management services to the list of primary care services that would serve as a basis for beneficiary assignment to an ACO.

Philips Comments: Philips strongly supports this proposal, and believes that both transitional and chronic care management are critical primary care services.

Payment for Telehealth Services. CMS is soliciting comments on whether the originating site and geographic restrictions currently included in the Medicare telehealth benefit should be waived for ACOs participating in Track 3 ACOs, to whom beneficiaries are assigned on a prospective basis. The Proposed Rule seeks comment on:

- Whether the geographic restrictions currently applicable to telehealth services also should be waived for Track 2 ACOs;
- What other telehealth or other Medicare requirements should be waived in order to facilitate the provision of telehealth services to ACO patients;
- How should telehealth be defined for these purposes;
- Under what circumstances should payment for telehealth and related services be made;
- What types of services should be included – remote monitoring, remote visits and/or e-consults; and
- What capabilities should ACOs meet in order to qualify for payment for telehealth services under such a waiver.

Philips Comments: Philips urges CMS to adopt a policy that facilitates broad coverage of telehealth services for Medicare beneficiaries assigned to all ACO tracks (1,2,3). This policy should include waiver of the current geographic and originating site restrictions for all ACOs, the adoption of a broad definition of telehealth for ACO coverage purposes, and the coverage of innovative telehealth services that meet this definition—regardless of whether these services substitute for a face to face encounter.

As demonstrated by the examples cited in this letter, the appropriate provision of services through telehealth has the potential to improve quality and reduce costs regardless of the originating site and the geographic location of the patient population served. In particular, there is a significant potential to achieve these objectives for patients in lower-cost settings, especially in the home.

We also believe that it is important for Medicare to adopt a broader definition of telehealth for ACO coverage purposes than the definition used by the Medicare fee for service program. Philips defines telehealth as:

"The use of remote sensors, communications and data processing technologies that focus on the patient/person and involves dynamic interaction with providers in real-time or near real-time resulting in improved clinical outcomes, lower costs and greater satisfaction. Telehealth technologies include bi-directional audio/video, physiologic and behavioral monitoring, engagement prompts and point-of-care

testing. Telehealth programs utilize remote teams of physicians, nurses, pharmacists, social workers and health coaches supported by this enabling technology to provide the highest quality health care."

We urge CMS to adopt this definition for the purposes of providing coverage for telehealth services provided to Medicare beneficiaries assigned to ACOs.

We note that this definition extends considerably beyond the definition of telehealth services currently used by CMS in administering fee-for-service Medicare. CMS' current telehealth definition limits coverage to those telehealth services that are virtually identical to covered face-to-face services, but are provided remotely rather than in-person. Such a definition fails to accommodate telehealth services that are of value precisely because they incorporate innovative, systems-enhancing and team-based approaches that are not analogous to current delivery models. The telehealth definition proposed above encompasses a broad range of technologies that can enable successful telehealth programs; it also underscores the need to look beyond current "telemedicine" definitions, which limit coverage to the remote provision of currently covered services, such as e-consults and remote physician visits. Our programs demonstrate that the potential to increase access, reduce costs and improve outcomes through well-designed telehealth programs goes far beyond the current limited definition.

Finally, we note that the provision of coverage for telehealth services that are not currently covered under fee-for-service-Medicare may be insufficient incentive for some ACOs to adopt this technology, in light of the up-front investment and implementation costs involved. For this reason, we urge CMS to consider increasing the shared savings percentage for ACOs that take on the management of patients with multiple chronic conditions for whom telehealth solutions are especially promising.

Philips appreciates the opportunity to comment on these important issues.

Sincerely,

Brian Rosenfeld, M.D.
Vice President and Chief Medical Officer
Philips Telehealth