



May 14, 2010
Secretary Kathleen Sebelius
Secretary Timothy Geithner
Room 445-G
Department of Health and Human Services
Attention: DHHS–2010–MLR
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act

Dear Secretary Sebelius and Secretary Geithner,

We are writing in response to the Request for Comments Regarding Section 2718 of the Public Health Service Act (PHSA), 75 Fed. Reg. 19297, April 14, 2010.

The Continua Health Alliance (www.continuaalliance.org) is a non-profit, open industry coalition of over 230 healthcare, technology and medical device companies who have joined together in collaboration to improve the quality of health through the use of telehealth, personal connected health, and independent living technologies for what has been termed “eCare” by the Federal Communications Commission and the U.S. Senate.¹ Continua is dedicated to establishing interoperable personal health solutions with the knowledge that extending those solutions for “electronic care” into the home fosters independence, empowers individuals, and provides the opportunity for personalized health and wellness. Continua believes that eCare products and services are critical services that improve the delivery of healthcare and quality of care.

We appreciate this opportunity to describe the importance of implementing the medical loss ratio (MLR) requirements under section 2718 of the PHSA in a way that does not discourage innovative patient care, specifically, the use of personal connected health, telehealth and eCare. These technological advances provide tremendous clinical value and must be considered “clinical services” within the meaning of PHSA § 2718(a)(1) or activities that “improve health care quality” within the meaning of PHSA § 2718(a)(2).

In general, we believe that health plan expenditures that affect patient outcomes and behaviors should be considered medical services, whereas expenditures that go towards collecting revenue

¹ See: FCC National Broadband Plan: Connecting America, released March 16, 2010, at Page 200. See U.S. Senate Special Committee on Aging, Committee Hearing on April 22, 2010 “Aging in Place: The National Broadband Plan and Bringing Health Care Technology Home” http://aging.senate.gov/hearing_detail.cfm?id=324102&.

or billing for services should be considered administrative. Personal connected health and telehealth fall on the side of improving patient outcomes and behaviors, and are vital to the continued evolution of a modern, cost effective and efficient healthcare system and should therefore be encouraged as you implement the MLR requirements.

I. Introduction to Personal connected health, Telehealth, and eCare

Continua uses the term “eCare” to refer to the class of health information technologies that can facilitate any kind of virtual visit or electronic connectivity outside of traditional office visits among patients, family members, and medical professionals. eCare includes personal connected health as well as telehealth. eCare could simply mean secure text messaging between a senior patient and their doctor to change a medication dosage, or an audio chat, or a full video web cam visit as well. It can also mean personal connected health with an in-home or mobile broadband device that can help providers track and trend data like blood pressure and weight fluctuations that seniors and other patients can take by themselves on a regular basis. eCare may also include using connectivity to help patients remember to take a medication, capture a vital sign, or to view customized content sent to them by their doctor to teach them about managing their own disease. eCare is not a substitute for care providers, physicians or clinicians – it is intended to augment and extend the good work of medical professionals by collapsing time and space, making information available to and from patients anywhere, anytime.

To realize the quality improvement and cost-containment goals of health care reform, our nation must harness the benefits of technologies that allow patients and care providers to use real-world, remotely collected data to make decisions about their health on a continuous basis, rather than wait until a condition has set in and requiring the patient to urgently schedule an office visit or go to the emergency room. By tracking vital signs and other health data on a more regular basis and sharing it through secure systems, eCare offers many beneficial clinical capabilities:

1. Empowering patients with tools that help them make sense of—and to manage—their own care;
2. Collecting real-world biological and behavioral data and trends on a daily basis with alerts for out-of-norm situations;
3. Facilitating virtual visits with providers, whenever and wherever appropriate, via a range of electronic media;
4. Enabling social networking, awareness, and care support from family and friends who are nearby or distant;
5. Personalizing care plans and educational content for each patient based on their needs, preferences, data, and capabilities; and
6. Triaging precious medical resources to enable the right amount of care to occur in the right place and time.

These current services and future health information technologies will be the key to improving the delivery of clinical services and health care quality, as well as containing healthcare costs. Many studies have shown the value of personal connected health. For

example, the New England Healthcare Institute (NEHI) “2008 Research Update, Remote Physiological Monitoring” found that remote patient monitoring resulted in a 60 percent reduction in hospital readmissions compared to standard care and a 50 percent reduction in hospital readmissions compared to disease management programs without monitoring. The same study found that remote patient monitoring has the potential to prevent between 460,000 and 627,000 heart failure related hospital readmissions each year. Based on this reduction in readmissions, NEHI estimated annual national cost savings of up to \$6.4 billion dollars.

As our nation looks for ways to improve quality, access, and costs of healthcare, it is important to realize that eCare technologies can save lives and dollars. For example, the Department of Veterans Affairs (VA) studied this issue in their report, “Care Coordination/Home Telehealth: The Systemic Implementation of Health Informatics, Home Telehealth and DM to support the Coordination of Veteran Patients with Chronic Conditions.” The VA found that implementing telehealth to coordinate patient care led to a 25 percent reduction in the number of bed days and a 20 percent reduction in hospital admissions. The report showed a cost of \$1,600 per patient per annum for the telehealth program compared to \$13,121 for primary care and \$77,745 for nursing home care. Not only were patients able to avoid readmission and improve their health status faster through telehealth services, but taxpayers also saved money.

The significant investments in health information technology (HIT) infrastructure made through the American Recovery and Reinvestment Act (ARRA) and health care reform are an important starting place for improving our country’s capacity to provide high quality and efficient care. Without a national infrastructure—an “electronic highway” for health information—it will be impossible for the United States to deliver quality care to more people at lower costs as the nation ages. With the passage of AARA, our nation took a leap forward in relation to electronic health records by allocating \$19.2 billion towards adoption of HIT. That investment is just one step. *eCare is the next step forward, and without its inclusion in the MLR definitions of clinical services or activities that improve the health care quality, the significant dollar investment made by the federal government stops short of moving the system beyond just the use of records.* eCare can populate electronic medical records with trend data and other timely information to provide a more complete picture of a patient and to empower providers to make clinical decisions that improve the health and lives of Americans.

II. Role of Personal Connected Health, Telehealth and eCare as Clinical Services and as Improving Health Care Quality

In the request for comments on the PHSA § 2718 MLR rules, the Departments of Health and Human Services (HHS), the Treasury, and Labor request information on the pros and cons associated with including various kinds of activities on lists of activities that improve health care quality. 75 Fed. Reg. 19297, 19300. The types of services that will be viewed as “clinical services” under PHSA § 2718(a)(1) will be equally important for the agencies to consider carefully. Continua believes that sufficiently broad definitions of these terms that include personal connected health, telehealth and eCare services will be critical to aligning incentives under the MLR requirements with the goals of healthcare reform.

eCare, including personal connected health and telehealth, complements clinic and hospital visits and improves healthcare quality. By monitoring their own data from home, patients and their caregivers become more engaged in self-care. eCare can also improve consumers' access to care, particularly in rural areas, by easing logistical burdens and reducing or eliminating the need to travel to a provider's office for routine checkups. In addition, through the use of personal connected health, providers have more information on a timely basis upon which to make medical decisions that can assist in addressing health problems before they become crises.

Recognizing these challenges and opportunities, the Patient Protection and Affordable Care Act (PPACA) includes numerous provisions designed to promote personal connected health, telehealth, and other eCare services. For example, the Secretary of HHS is required to develop guidelines for a payment structure that provides increased reimbursement or other incentives for: improving health outcomes including through quality reports, case management, care coordination, chronic disease management, medication and care compliance initiatives (including medical home); activities to reduce hospital readmissions; activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology; and wellness and health promotion activities. PPACA § 1311. eCare is at the crux of all of these services.

PPACA also recognizes that many meaningful physician encounters can occur remotely. Specifically, the Act allows certification or re-certification of a patient for home health services or durable medical equipment to occur through a face-to-face physician encounter or through the use of telehealth. PPACA § 6407. In another example, a Medicare health risk assessment may be furnished through an interactive telephonic or web-based program that meets standards to be established by the Secretary of HHS. PPACA § 4103. PPACA also provides for investment in community-based collaborative care networks that expand capacity through telehealth and medication management services (MTM) that are provided either in person or through telehealth technologies. PPACA §§ 10333, 10328. These programs will both encourage the uptake of beneficial health information technologies throughout the healthcare system and address critical shortages of healthcare providers. Expanding the use of eCare will be paramount to providing high quality care for the increasing number of individuals who are living with chronic and expensive health conditions for longer than ever before. Continua urges all payors for health services to be mindful to adopt eCare technologies. However, if the MLR definitions are not broad enough to encompass eCare technologies, we fear that insurance issuers will not make necessary investments to continue eCare development both in terms of technology innovation and appropriate clinical use within the health care system. Without buy-in across government and private payors, the opportunities for eCare to enhance our healthcare system as recognized in PPACA will not be realized across our healthcare system.

Many of the most promising ideas for health care delivery innovation depend on eCare services. PPACA looks to increase the use of e-Care services to provide for future improvement in healthcare delivery. For example, the Independence at Home Demonstration Project, designed to improve care for chronically ill Medicare beneficiaries, defines an "independence at home

medical practice” as one that “uses electronic health information systems, remote monitoring, and mobile diagnostic technology.” PPACA § 3024. Accountable Care Organizations participating in shared savings programs under PPACA are required to “define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, personal connected health, and other such enabling technologies.” PPACA § 3022. Further, the Center for Medicare and Medicaid Innovation created by PPACA may test models that support care coordination through “a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology,” and may consider whether a model under review “utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.” PPACA § 3021.

Without inclusion of eCare, from the beginning, as a clinical service or service that improves quality, our healthcare system will not benefit from or encourage the use of personal connected health or telehealth services for all patients. In making decisions about MLR implementation, we urge you to look to the future of what healthcare delivery can be through the use of wired, wireless, mobile and whatever new forms of technology may appear to allow our uniquely American healthcare system to benefit from eCare as we know it and as we might know it in the future. We will look back some day on eCare solutions and wonder how we ever had effective and ethical care without them.

Services that change patient behavior, assist in treatment and patient compliance, and improve quality are supported by information technologies. These technologies serve as the backbone for the provision of a variety of activities including wellness, disease management, medication management services and health prevention – all important goals of PPACA. Over time, this infrastructure will need to be improved and augmented in order to support these activities particularly as these services become better integrated into our overall health care delivery system. As our reliance on information technology systems grows, they should also be considered a part of those services that improve quality. Without the vital services of eCare, our healthcare delivery system will be limited and not help move healthcare into the 21st century.

Technology is evolving rapidly. The rapid societal uptake of now-commonplace devices from smartphones, to netbooks, to smartbooks, demonstrates the pervasive role of wireless technology in our daily lives and the opportunities they bring to improve our access to healthcare. As we learn and develop “best practices” for eCare—and invest in comparative effectiveness studies to know the right balance of in-home, in-clinic, and eCare consultations for different conditions and needs—these technologies will ultimately help us move beyond a quantity oriented system (e.g., number of visits done or tests or drugs prescribed) to one of quality.

Because eCare services, including personal connected health and telehealth provide clinical value and improve the quality of patient care, they should be considered part of a health plan’s medical expenses.

Secretary Kathleen Sebelius

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The Continua Health Alliance thanks you for the opportunity to provide valuable input into this proceeding and we look forward to working with you in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "Charles Parker". The signature is fluid and cursive, with the first name "Charles" being more prominent than the last name "Parker".

Charles Parker

Executive Director

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