

June 13, 2017

Ms. Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1677-P  
Mail Stop C4-26-05  
7500 Security Blvd.  
Baltimore, MD 21244-1850

**RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates (Proposed Rule); RIN 0938-AS98**

Dear Administrator Verma:

On behalf of Philips, I am pleased to have the opportunity to respond to the Proposed Rule's solicitation of comments on innovative ways to improve the quality and efficiency of services provided to Medicare beneficiaries. 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 a complete range of comprehensive telehealth programs.

These comments focus on the potential role that expanded coverage of telehealth services could play in improving the quality and efficiency of services provided to Medicare beneficiaries, and, in particular the unique role that remote provision of ICU coverage (eICU) could serve in achieving these objectives.

Philips believes that coordinated telehealth programs are among the most cost-effective solutions to systematically manage patient populations with ongoing needs, particularly those with medically complex and/or chronic conditions. 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. Philips telehealth programs include the Remote Intensive Care Program (eICU®), a comprehensive technology and clinical reengineering program that enables health care professionals from a centralized telehealth center to provide around-the-clock care for critically ill patients; eAcute Program, which is modeled after the eICU, and monitors high-risk hospitalized patients on medical-surgical floors to prevent avoidable complications, and eConsultant Program, which provides remote management services to Skilled Nursing Facilities (SNFs) and emergency department (ED) consults for telestroke, telepsych and trauma triage; and the Intensive Ambulatory Care (eIAC) Program, through which Philips partners with providers to manage high-risk patients with multiple chronic conditions in the home.

Unfortunately, policymakers currently appear to adopt a limited definition of telehealth, conceptualizing telehealth as the remote provision of services that otherwise may be provided

face-to-face by an individual provider. In fact, however, telehealth offers benefits—especially in terms of remote monitoring-- that are unique, and that are not currently provided during face-to-face encounters with individual healthcare practitioners. Telehealth is more accurately defined as follows:

Telehealth is 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.

*Recommendation: We strongly urge CMS to redefine telehealth more broadly along the lines set forth above and to incorporate quality measures related to telehealth in the pay-for-value programs applicable to physicians, hospitals, SNFs, and other providers.*

In considering the potential contributions of telehealth to the quality and efficiency of services provided to Medicare beneficiaries, we urge CMS to first examine the cost savings achievable through the eICU. A project funded by CMS through the Centers for Medicare and Medicaid Innovation (CMMI) entitled “Rapid Development and Deployment of Non-Physician Providers in Critical Care” clearly establishes the cost savings and quality improvement achievable through increased use of the eICU, with on-site coverage provided by specially trained Nurse Practitioners and Physician Assistants. **CMS has publicly reported that this e-ICU based care model resulted in \$18,400,000 in Medicare savings during the demonstration period.** <https://innovation.cms.gov/initiatives/participant/Health-Care-Innovation-Awards/Emory-University.html>. And these savings do not consider the savings that accrued to patients and non-Medicare payers, which were likewise extraordinary

This project, instituted by Emory University in partnership with Philips Healthcare and several regional medical centers, sought to improve care, value, and access for patients by addressing the critical care staffing shortage. Implementing an eICU program to remotely monitor ICU patients on a continuous basis helped care teams to recognize patients in need of immediate attention so they could intervene more quickly. Since the implementation of this program, Emory has provided care to more than 20,000 patients in five hospitals across Georgia, while saving millions of dollars in costs.

Emory Healthcare’s eICU success was recently highlighted in the 3rd annual “[Evaluation of Hospital- Setting HCIA Awards](#)” report by Abt Associates, conducted on behalf of the CMS. This three-year independent audit analyzed financial and clinical outcomes at organizations that received CMS Innovation grants and concluded that Emory achieved the following results across its 136 beds at five hospital sites:

- A \$1,486 reduction in average Medicare spending per 60-day episode relative to the comparison group, yielding an estimated savings of \$4.6 million around care of these federal beneficiaries during the 15 month comparison period. (p<0.01).
- A 4.9 percentage point increase in the relative rate of discharges to home health care, while discharges to skilled nursing facilities and long-term care hospitals declined by 6.9 percentage points (p<0.01), indicating that Emory was discharging patients with less need for institutional post-acute care after their eICU stay.
- A 2.1 percentage point decrease in the rate of 60-day inpatient readmissions (p<0.10) relative to the comparison group. Medicare pays for home health care in 60-day increments, and more of Emory's patients were discharged with home health care, which may have contributed to this reduction in 60-day readmissions.

Additionally, the survey portion of the audit showed that patient satisfaction of those who received care at Emory's facilities was more favorable than reported by the comparison group. The findings also suggest that the eICU program at Emory helped improve affiliate provider training and increased the number of patients that one intensivist could cover.

*Recommendation: The results of the CMMI project support the extension of e-ICU coverage to intensive care units throughout the country. At the very least, CMS should institute a follow-up demonstration to confirm that these savings and quality improvements can be achieved more broadly using the care model tested by Emory.*

We appreciate the opportunity to provide these comments and would be pleased to meet with you to chart a course for incorporating the extraordinary results of this demonstration into Medicare coverage and payment policy for providers throughout the country.

Sincerely yours,

Lucy McDonough  
Director Market Access North America  
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