December 31, 2018

Attention: CMS-4185-P
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: *Multi-stakeholder Comments to the Centers for Medicare and Medicaid Services on* Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 *(83 FR 54982)*

The Connected Health Initiative (CHI) writes to respond to the Centers for Medicare and Medicaid Services' (CMS') proposed rule,[1] particularly regarding proposed "additional telehealth benefits" as part of basic Medicare Advantage (MA) benefits, per the Bipartisan Budget Act of 2018, Pub. L. 115-123 (BBA).

CHI is the leading effort by stakeholders across the connected health ecosystem to clarify outdated health regulations, encourage the use of digital health innovations, and we support an environment in which patients and consumers can see improvements in their health. We seek policy changes that will both enable all Americans to realize the benefits of an information and communications technology-enabled healthcare system and levering patient-generated health data (PGHD) in prevention and treatment. For more information, see www.connectedhi.com.

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CHI is a long-time active advocate for the increased use of innovative technology in the delivery of healthcare and engages with a broad and diverse cross-section of industry stakeholders focused on advancing clinically validated digital medicine solutions. For example, Morgan Reed, executive director of CHI and president of its convening organization ACT | The App Association, is an appointed member of the American Medical Association's (AMA) Digital Medicine Payment Advisory Group, an initiative bringing together a diverse cross-section of 15 nationally recognized experts to identify barriers to digital medicine adoption and propose comprehensive solutions regarding coding, payment, coverage, and more.[2] CHI is also a board member of Xcertia, a collaborative effort to develop and disseminate mHealth app guidelines that can drive the value these products bring to the market. These guidelines also seek to increase the confidence that physicians and consumers can have in these apps and their ability to help people achieve their health and wellness goals.[3]

CHI agrees that the "additional telehealth benefits" provided for in the BBA should be defined as services furnished by MA plans for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Social Security Act and have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange. We specifically support providing MA plan sponsors with the discretion to make the determination that the telehealth services are clinically appropriate as opposed to limiting coverage to only those services CMS covers under the telehealth benefit. However, we urge CMS to note that the definition only applies to telehealth as specified under Part B - specifically, two-way audio and visual real-time and interactive services. Furthermore, CMS should note that all other virtual services, such as remote patient monitoring, are not considered telehealth and therefore are not subject to restrictions as CMS has stated recently in the 2018 and 2019 Physician Fee Schedule[4] and the 2019 Home Health Rule.[5] As a result, MA plan sponsors are already able to include other virtual services, including remote patient monitoring, in the basic benefits so long as considered clinically appropriate, providing a pathway for the use of innovative digital tools in MA.

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[2] https://www.ama-assn.org/delivering-care/digital-medicine-payment-advisory-group

[3] http://www.xcertia.org/

[4] CMS, *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program*, 83 Fed Reg 35704 (Nov. 23, 2018).

[5] CMS, *Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations*, 83 Fed Reg 56406 (Nov. 13, 2018).

Please also note that in this draft rule, as required by Section 50323 of the BBA, CMS proposes to allow MA plans to cover Part B benefits provided via electronic exchange as “additional telehealth benefits” and as a basic benefit as defined in § 422.101. Created by the BBA, section 1852(m) of the Social Security Act allows MA plans to provide “additional telehealth benefits” to enrollees starting in plan year 2020, and to treat such services as basic benefits for purposes of bid submission and payment by CMS. The BBA limits these authorized “additional telehealth benefits” to services for which benefits are available under Medicare Part B, but that are not payable under section 1834(m) and have been identified for the applicable year as clinically appropriate to furnish through “electronic information and telecommunications technology.” In its efforts to implement the BBA, CMS has noted in the preamble that “[e]xamples of electronic information and telecommunications technology (or ‘electronic exchange’) may include, but are not limited to, the following: secure messaging, store and forward technologies, telephone, videoconferencing, other internet-enabled technologies, and other evolving technologies as appropriate for non-face-to-face communication.” We strongly urge CMS to rescind this preamble language and leave the proposed regulatory language as outlined: “[e]lectronic exchange means electronic information and telecommunication technology.”

CMS must reapproach its implementation of Section 50323 of the BBA to ensure MA’s alignment with CMS’ established approaches to Medicare telehealth services, as well as to remote patient monitoring and other “remote communications technology” that CMS has expressly stated do not fall under 1834(m) and its restrictions. Further, we urge CMS to expressly state that remote patient monitoring technologies may be included as part of basic MA benefits and are not subject to 1834(m).

We commend CMS for its efforts to advance the uptake of connected health innovations across its programs, particularly through recent program changes made for calendar year (CY) 2019. For example, in the CY 2019 Physician Fee Schedule (PFS), CMS has activated and provided payment for three new Current Procedural Terminology® (CPT) Codes that capture the technical and professional elements of remote patient monitoring, and has allowed home health agencies to include evidence-based remote patient monitoring expenses used to augment the care planning process as allowable administrative costs that are factored into the costs per visit under the Home Health Prospective Payment System (HHPPS). CMS has also put key incentives in place for the future value-based Medicare system, as well as to take steps to promote flexible use of PGHD in care coordination in the Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS). As a community, we continue to support CMS’ efforts to utilize advanced technology to augment care for every American patient.

With approximately one in three Medicare beneficiaries enrolled in an MA plan, it is essential that MA rules allow for caregivers and beneficiaries to realize the benefits associated with leveraging PGHD collected by connected health technology, consistent with key policy changes already made in other payment systems such as those noted above. We support the greater use of Medicare telehealth services in MA plans and support the waiver of the outdated section 1834(m) restrictions.

We appreciate CMS seeking input on its draft rule, and for its partnership in leveraging the incredible potential of connected health technologies. We encourage CMS' thoughtful consideration of the above input and stand ready to assist further in any way that we can.

Sincerely,

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