ConnectedHealthInitiative

February 14, 2024

Gift Tee
Director, Division of Practitioner Services
Hospital and Ambulatory Policy Group
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Washington, District of Columbia 20201

Dear Director Tee:

CHI, the leading multistakeholder policy and legal advocacy effort driven by a consensus of stakeholders from across the connected health ecosystem, writes to share recommendations for the Center for Medicare and Medicaid Services' (CMS) future Calendar Year (CY) 2025 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) rulemaking.

Digital health technologies are essential in improving beneficiary outcomes, reducing costs, and mitigating disparities in healthcare. Thanks to CMS' quick action, the use of digital health services and related technologies have expanded and demonstrated value across a range of use cases. These tools and services have allowed Americans across every walk of life – from urban centers to underserved rural geographies – great access to vital medical services for both acute and chronic conditions while ensuring public safety during the pandemic. In its rulemaking for CY 20253, CMS should leverage every opportunity to incentivize the responsible use of innovative digital health technologies and ensure that no American beneficiary is left behind.

<u>Specifically, we recommend you consider the following in the CY 2025 PFS:</u>

- **Remote Physiologic Monitoring:** We appreciate and support CMS' approach to remote physiologic monitoring (RPM) CPT® codes 99091, 99453, 99454, 99457, and 99458. Given the demonstrated role of RPM tools in treating chronic and acute illnesses, CMS should provide further policy-level clarifications in its CY 2025 PFS rule, including:
    - CMS should permanently permit RPM services to be furnished to both new and established patients, and for consent to be obtained verbally. During the PHE, CMS clarified on a permanent basis that RPM services may be applied for patients with acute and chronic conditions. To require patients who present with acute conditions to have an established relationship with a provider, runs contrary to the notion of reasonable and necessary.
    - Contrary to what has expressed in past Fee Schedules and reiterated by CMS in the 2024 Final Rule, CMS should reconsider allowing multiple providers the ability to report RPM codes 99453, 99454, 99457, and 99458. Under current CMS policy, only one provider, in a 30-day billing period, may bill RPM for a given patient. Doing so undercuts the ability for multiple specialists from remotely monitoring a single patient, even when monitoring and treating separate episodes of care.

  - CMS should permit physicians to perform and separately bill/report RPM during a global surgical period when related to the global surgical event. Such support is necessary to provide medically necessary routine follow-up care for many beneficiaries in the post-surgery stage of their care.
  - CMS should consider clarifying whether there are any extraordinary provider documentation requirements when reporting RPM and RPM Treatment Management Services (RPM-TMS) codes.
- **Remote Therapeutic Monitoring:** We continue to support CMS' adoption, coverage, and payment of Remote Therapeutic Monitoring (RTM) and Remote Therapeutic Monitoring Treatment Management Services (RTM-TMS) CPT® codes 98975, 98976, 98977, 98980, and 98981. While the use of new RTM tools are improving beneficiary care already, several areas of need for clarifications have emerged:
  - CMS should continue to clarify the shared or divergent policy nuances between RTM and RPM services such as whether RTM is allowed for patients with acute and chronic conditions, if RTM requires an established provider patient relationship, and how consent may be obtained, which non-physician providers may bill/report RTM services (as they are General Medicine and not Evaluation and Management), if RTM may be billed in conjunction with 99091, and how "interactive communication" is defined for RTM specifically.
  - In the 2023 Physician Fee Schedule Final Rule, RTM CPT Code 98978 (to supply equipment that monitors cognitive behavioral therapy) was assigned to "contractor pricing." Presumably 98978 has remained under contractor pricing through the present and onward. Given the country's unprecedented (and growing) need for behavioral and psychological services, the availability of medical tools such as those addressed via 98978 should be a priority. We request that CMS elaborate on which MAC's have assessed the payment of 98979 and whether any have adopted, covered, and paid 98978? If so, at what level of reimbursement? If not, can CMS provide the rationale as to why this active CPT code has been rejected?
  - CMS should provide elaborative language clarifying the broad range of use cases allow under the RTM work codes (98980 and 98981) beyond musculoskeletal and respiratory – common interpretation is that similar to the physiologic codes (99457 and 99458) that any therapeutic medical condition (acute or chronic, when reasonable and necessary, and when addressed in combination with a digital medical device that automatically – that is digitally – uploads the medical device data to the provider) should be permissible in order to report 98980 and 98981 – as opposed to the PE only RTM equipment supply codes (98975, 98976, 98977, and 98978) which require devices that address specific medical conditions (i.e., respiratory, musculoskeletal, and cognitive behavioral therapy).
  - CMS should permit multiple providers the ability to concurrently report RTM services, for the same patient, per-30 day period, consistent with our similar recommendation for RPM above.
  - CMS should permit RTM to be billed separately during a global surgical period that it is related to the global surgical event. Such support is necessary to provide medically necessary routine follow up care for many beneficiaries in the post-surgery stage of their care. RTM services should be considered an adjunct service and not covered by the pos-surgical global period.

- **Artificial Intelligence (AI):** As CMS' continues to discuss and explore how to responsibly bring AI to the Medicare system to advance health equity to all patients, consistent with detailed recommendations provided to CMS separately,[1] we encourage the following:
    - Leveraging consensus medical AI terminology[2] and CHI's cross-sectoral consensus understanding of the unique roles and interdependencies/shared responsibilities amongst the healthcare AI value chain[3] as a baseline for CMS' approach to health AI;
    - Building on the leading efforts of the National Institute of Standards and Technology's voluntary AI Risk Management Framework[4] to ensure that a coordinated approach is taken to health AI that scales risk mitigation requirements to intended uses and known harms;
    - Helping build trust amongst providers and beneficiaries by enhancing transparency consistent with CHI's recommendations in *Advancing Transparency for Artificial Intelligence in the Healthcare Ecosystem*;[5]
    - Advancing Medicare coverage and payment policy changes that appropriately categorize AI (e.g., recognize that AI software as a medical device is appropriately categorized and paid for as a direct practice expense) and responsibly expanding support for AI's use in the prevention and treatment of beneficiaries' acute and chronic conditions;
    - Continue engaging in dialogue with the digital health community to inform new steps forward towards an expanded and nationally-harmonized approach to AI's use in Medicare.
- **Medicare Diabetes Prevention Program:** CMS is long overdue to offer virtual Medicare Diabetes Prevention Program (MDPP) services yet continues to refuse to propose meaningful changes that would do so. We strongly encourage CMS to, in its CY 2023 PFS rule, permanently expand the MDPP to support virtual providers and virtual encounters.
- **Medicare Telehealth Services:** Under its new and reorganized approach per the CY 2024 final PFS rules, CMS should continue support for telehealth services to the maximum extent possible. We urge for the appropriate expansion of support for Medicare telehealth services in the CY 2025 PFS, including in the the case of mental telehealth services, to ensure equitable access for all beneficiaries.

[1] https://actonline.org/wp-content/uploads/CHI-AI-Ltr-to-CMS-Feb-9-2022.pdf.

[2] E.g., https://www.ama-assn.org/practice-management/cpt/cpt-appendix-s-ai-taxonomy-medical-services-procedures.

[3] https://connectedhi.com/wp-content/uploads/2024/02/CHI-Health-AI-Roles.pdf.

[4] https://www.nist.gov/itl/ai-risk-management-framework.

[5] CHI's recommendations on necessary policy changes to enhance transparency for healthcare AI are available at https://bit.ly/3Gd6cxs.

Building on detailed recommendations developed by CHI's Value-Based Care Task Force,[6] we request that CMS support the responsible use of digital health tools in the Quality Payment Program (QPP) by, in its draft CY 2025 QPP rule, proposing that:

- **Merit-based Incentive Payment System:** We encourage CMS to continue to incent the flexible use of digital health technology throughout the Merit-based Incentive Payment System (MIPS), building on its integration of telehealth, remote monitoring, and AI technologies into various QPP Merit-based Incentive Payment System quality measures. CMS should also avoid (1) overburdensome MIPS Promoting Interoperability program compliance and reporting requirements to avoid burnout related to electronic health record use and (2) technology-specific mandates that reduce ability to adopt and scale the use of digital health tools to best provide value to beneficiaries.
- **Alternative Payment Models:** We share CMS' goal of developing a vibrant, diverse, and inclusive set of Alternative Payment Models (APMs) that will drive value for all beneficiaries. Digital health innovations must play a central role in successful APMs. CMS should clearly endorse the use of digital health technologies' role in the success of APMs in its CY 2023 QPP rule. We urge CMS to utilize every opportunity available to move away from legacy measurement programs and towards a truly connected continuum of care through its implementation of the QPP.

We value CMS' collaboration and appreciate consideration of our input above. We stand ready to assist further in any way that we can.

Sincerely,

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[6] https://www.connectedhi.com/blog/2021/7/14/the-value-based-care-revolution-will-stall-without-health-tech.