January 26, 2016

The Honorable Orrin Hatch
Chairman, Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
U.S. Senator
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
U.S. Senator
U.S. Senate
Washington, DC 20510

Delivered by Email to: chronic_care@finance.senate.gov

Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

The Personal Connected Health Alliance (PCHA), a collaboration between HIMSS, the mHealth Summit, and the (former) Continua Health Alliance, extends its appreciation for your policy work to improve care provided to Medicare patients with chronic conditions and is excited to share its comments on the "Bipartisan Chronic Care Working Group Policy Options Document." PCHA shares the Working Group's commitment to transform the delivery of chronic disease care. We urge the Working Group, as detailed in comments below, to embrace and advance policies that permit the use of remote patient monitoring, not as a stand- alone intervention, but rather as a tool that permits delivery of 21st century care to patients by providers. Specifically, we ask the Working Group to include in its chronic care improvement legislation the Clinical Opportunities for Novel and Necessary Effective Care Technologies (CONNECT) for Health Act, which is under development by Senators Schatz, Wicker, Cochran, Cardin, Thune, and Warner. This legislation is closely aligned with the Working Group proposals, and it offers a thoughtful approach to improve chronic condition care through targeted telehealth and remote patient monitoring Medicare coverage.

PCHA is the leading organization advocating for global technology standards for personal connected health. PCHA publishes the *Continua Design Guidelines*, which provide a flexible implementation framework for authentic interoperability of personal connected health devices and systems and convenes the mHealth Summit, the largest gathering of its kind focused solely on connected health. PCHA also works closely with regulators, government agencies and industry to create the technology 'ecosystem' required for delivering on the promise of personal connected health. More than 100 companies, healthcare systems, and governments work together to advance PCHA's mission of interoperable, patient-focused connected health.

PCHA's U.S. policy work focuses on the policy implementation of chronic care use cases for personal health care technologies that are well developed with extensive clinical trial support. If clinical evidence

alone were to dictate care delivery methods, then use of remote patient monitoring (patient generated health data sent to providers to monitor health and/or conditions) for those with chronic diseases would be the standard method by which providers would engage in care for individuals with chronic conditions. However, reimbursement policy also drives care delivery methods, and, because only face to face, real time care is reimbursed, remote patient monitoring is not deployed by our nations' caregivers and patients.

We offer the following comments on the "Bipartisan Chronic Care Working Group Policy Options Document:"

Comments regarding Proposals on Receiving High Quality Care in the Home:

Expanding the Independence at Home Model of Care: PCHA supports the Committee's proposal to expand the current IAH demonstration into a nationwide program and urges the Committee to waive the 1834(m) telehealth restrictions from IAH care delivery. The IAH demonstration had, at its core, a requirement for digitally enabled interoperable use of information technology. But, 1834(m) telehealth restrictions truly impede innovative and efficient use of telehealth enabled services. In many cases the IAH demonstration practices would be using remote patient monitoring to enable timely and early interventions, but for outdated and restrictive rules on telehealth. It is important to note that the IAH demonstration was modeled on the successful transformation demonstrated by the Veterans' Administration (VA), in which home based care is provided for those with multiple chronic conditions **using daily monitoring of patient generated health data (remote patient monitoring)** in conjunction with care coordination. Daily monitoring and digitally enabled communication, offers a transformed delivery of care that reduces acute illness episodes, reduces chronic disease complications, and engages patients in self-care education.

Expanding access to Home Hemodialysis Therapy: PCHA supports the Committee's proposal to expand the originating sites for telehealth visits to include free-standing renal dialysis centers in any geographic location. In addition, PCHA urges the Committee to expand permitted originating sites for home dialysis patients to include the home. We believe that the physician conducting the visit can and will determine the best in person visit schedule based on patient condition, and urge the Committee to keep bureaucratic limits to a minimum so that care delivery can be provided on a patient centered basis.

This policy is embedded in the CONNECT for Health Act.

Comments on Proposals on Advancing Team Based Care

Improving Care Management Services for Individuals with Multiple Chronic Conditions:

Patients living with multiple chronic conditions are most at risk for high-cost health care services, such as increased hospitalizations and emergency room visits. With evidence showing that non-face to face care management improves care outcomes and reduces acute care episodes, CMS established in the 2015 Physician Fee Schedule a chronic care management CPT Code (99490), for

non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple (2 or more) chronic conditions. However, the specific needs of each patient living with multiple chronic conditions can vary widely, and as the Working Group acknowledges, the current structure and reimbursement rate of the existing code (99490) may be insufficient to deal with the acute episodes, complex cases, or the need for remote patient monitoring. While PCHA supports the proposed new high-severity chronic care management code, the very low use of the current chronic care management (CCM) service code reflects underlying usability issues. There is an urgent need for modifications to the CCM requirements to ensure CCM and high severity CCM can be used by providers and delivers valuable service to individuals. Among the barriers to use and benefit from CCM are onerous administrative documentation and prohibition on billing of essential co-delivered services like remote patient monitoring.

To make CCM and high-severity CCM useable by providers and beneficial to individuals with chronic conditions, we recommend the Committee to add the following to its improving care management proposal:

- ***Establish coverage for remote monitoring of patient generated health data when CCM is provided for individuals with 2 or more chronic conditions identified by the Secretary AND a history of 2 or more hospitalizations.*** This coverage would help align team based care with the clinical evidence on delivery of patient centered care for individuals with chronic conditions. For example, extensive clinical evidence shows that remote patient monitoring coupled with nurse review of physiological data, health coaching and electronically delivered patient education leads to stabilization of heart failure and COPD while lowering health costs[i,ii,iii,iv,v,vi,vii,viii]. The current CCM benefit does not cover any part of those services, yet they are the very services that are needed by individuals with multiple chronic conditions.

  This is an embedded component of the CONNECT for Health Act, and it is a crucial component to achieving cost efficiencies in conjunction with improving the quality of chronic care delivery.

- ***Direct CMS to permit practices to bill for a set of additional care management type services*** IF CCM time exceeds 20 minutes per month that is reimbursed by CCM and these other services are needed by individuals receiving CCM:
  - Home health and hospice supervision (G0181/G0182, currently may not be billed if CCM is billed);
  - End state renal disease services (which now may not be billed if CCM is billed);
  - Review of physiological data (CPT 99090 and CPT 99091, currently this code may not be billed in conjunction with any physician fee schedule service.)

- ***Require streamlined and rationalized documentation requirements for demonstrating CCM services.*** For example, the care plan requirements reflect digital interoperability that simply does not exist in today's meaningful use and electronic health record programs. It is vital that care plan interoperability requirements provide flexibility in the variety of ways that real interoperability is achieved.

Comments on Proposals Regarding Expanding Innovation and Technology

Increasing Convenience for Medicare Advantage Enrollees Through Telehealth: PCHA supports permitting MA plans to include telehealth services in its annual bid amount and urges that the permitted telehealth be broader than those services permitted under the traditional Medicare program. It is vital to permit and allow for evidence based telehealth care and the traditional Medicare program remains a 20st century benefit that does not reflect 21st century clinical evidence and technology.

In addition, we urge the Committee to explicitly permit MA plans to include remote patient monitoring for individuals with chronic diseases whenever the plan determines that clinical evidence supports its use. These services can be included in an MA plan's annual bid, at which time the evidence that supports the service can be cited.

This is an embedded component of the CONNECT for Health Act, and allows MA plans to innovate with evidence proven, cost effective delivery mechanisms.

Providing ACOs the Ability to Expand Use of Telehealth: PCHA supports modification of all originating site requirements for reimbursement of telehealth services for all ACOs, not just those accepting two-sided risk. In addition, PCHA urges the Committee to also either lift the originating site requirements or specify the home as the originating site. Without additional modification to the originating site requirements, the full benefit and efficiency that telehealth offers is limited. It is vital to allow for modernization of the telehealth benefit, in a manner that reflects the clinical evidence for individuals with chronic disease, and that is that effective, efficient telehealth can be delivered where people live, rather than through a cumbersome, complex, and expensive Medicare certified originating site.

This is an embedded component of the CONNECT for Health Act, and allows ACOs to innovate with evidence proven, cost effective delivery mechanisms.

Expanding Use of Telehealth for Individuals with Stroke: PCHA supports this proposal.

This is an embedded component of the CONNECT for Health Act.

Additional Recommendation – CMMI pilots for adoption and use of remote patient monitoring and telehealth as a bridge to MACRA/MIP: In addition to these proposals for expanding innovation and technology, PCHA urges the Committee to establish and require CMMI pilots for adoption and use of remote patient monitoring and telehealth to bridge physician practices from today's fee for service system into the future payment system of merit incentive payment and alternative payment models. It is essential that physician practices be provided with effective models and means to implement and bring into practice digital tools

that enable more effective delivery of care for individuals with chronic conditions. The use of remote patient monitoring and telehealth and the resources to transition to these new methods of care delivery is simply not being piloted. Yet, such pilots are urgently needed.

This is an embedded component of the CONNECT for Health Act, and is crucial to an effective and smooth transition to APMs and MIPS.

Transformation of care provided to Medicare beneficiaries with chronic disease is desperately needed and remote patient monitoring is a clinically demonstrated innovation that is essential to more efficient and effective care for individuals with chronic conditions. It is a tool that allows providers to provide care more effectively and more efficiently, but it is a tool is prohibited by outdated rules and lack of reimbursement in original Medicare, ACOs, bundled payments, and the MA program. The CONNECT for Health legislation provides targeted coverage for RPM and telehealth that allows for providers to adopt the proven, effective and efficient tools of RPM and telehealth to improve care to those with chronic conditions and we urge you to include the CONNECT for Health legislation in your chronic care proposal.

Please contact me if you need any additional information or have questions. PCHA welcomes the opportunity to work with the Chronic Care Working Group as it considers these and other exciting policy changes that can improve and transform our nation's care of Medicare beneficiaries with chronic conditions.

Sincerely,

Rob Havasy
Vice President, Personal Connected Health Alliance

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