



September 2, 2014

The Honorable Marilyn Tavenner
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: CMS-1612-P, Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2015

Dear Administrator Tavenner:

The undersigned organizations write to communicate broad stakeholder consensus in response to the Center for Medicare and Medicaid Services (CMS) proposed changes to the Medicare physician fee schedule.¹ We believe that telemedicine and remote patient monitoring solutions hold great promise in reducing inpatient care and readmissions, as well as improving care coordination, and we strongly urge CMS to utilize every opportunity to maximize their use. A modern, 21st century healthcare system must leverage innovations in communications technologies. However, outdated regulations that have restricted the use of telehealth and remote patient monitoring have long been a hindrance to progress in this

¹ See CMS, *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015*, 79 F.R. 40318-40540 (Jul. 11, 2014) ("NPRM").

space.² Generally, we urge CMS to work towards a connected healthcare system by removing barriers to the widespread use of advanced medical technologies. Below, we provide specific consensus views on various important aspects of the notice of proposed rulemaking (NPRM) related to non-face-to-face chronic care management (CCM).

We share with CMS the goal of improving communication and coordination among health professionals and the patient. Remote patient monitoring and patient-generated health data (PGHD) are increasingly being utilized to improve care, reduce hospitalizations, avoid complications and improve satisfaction, particularly for the chronically ill.³ In addition, the use of virtual chronic care management by the Department of Veterans Affairs resulted in a substantial decrease in hospital and emergency room use.⁴ A recent study predicted that remote monitoring will result in savings of \$36 billion globally by 2018, with North America accounting for 75% of those savings.⁵

The diverse stakeholders represented in this letter write specifically to provide comment to CMS regarding reimbursement for non-face-to-face CCM.

- **CMS should ensure that it prevents ambiguities in billing expectations, particularly with regard to standards for electronic health ICT in furnishing CCM.** We urge CMS to clarify the relationship in the NPRM between its proposal for health ICT requirements⁶ and its proposal for detailed health ICT certification standards⁷ so that stakeholders can know whether these are separate requirements or whether one is dependent on the other

² As a notable example, Section 1834(m) of the Social Security Act has resulted in arduous restrictions on telehealth services (see 42 CFR § 410.78). Recently, a broad cross-section of stakeholders in the healthcare space have relatively recently proposed that HHS Secretary Burwell waive 1834(m) restrictions on Accountable Care Organizations in the Medicare Shared Savings Program. See <http://bit.ly/1na1UrA>.

³ See, e.g., U.S. Agency for Healthcare Research and Quality (AHRQ) Service Delivery Innovation Profile, *Care Coordinators Remotely Monitor Chronically Ill Veterans via Messaging Device, Leading to Lower Inpatient Utilization and Costs* (last updated Feb. 6, 2013), available at <http://www.innovations.ahrq.gov/content.aspx?id=3006>.

⁴ See Darkins, et al., *Telemed J E Health*. 2008 Dec. 14 (10) 1118-26. doi: 10.1089/tmj.2008.0021.

⁵ See Juniper Research, *Mobile Health & Fitness: Monitoring, App-enabled Devices & Cost Savings 2013-2018* (rel. Jul. 17, 2013), available at http://www.juniperresearch.com/reports/mobile_health_fitness.

⁶ NPRM at 40365.

⁷ *Id.* at 40367.

- **CMS should ensure certainty in CCM eligibility requirements.** For example, CMS' proposed criteria for categorizing a patient's chronic condition's level of acuity is based on a subjective determination of a level of risk and feeds uncertainty for those making these crucial determinations.⁸ Rather, CMS should put forward eligibility criteria based on a beneficiary's diagnosis with specific chronic conditions. Furthermore, we urge CMS to clarify that specialists, as well as primary care physicians, may utilize the CCM code.
- **CMS should ensure that CCM RVUs account for the time spent delivering care management services.** In the NPRM, CMS proposed CCM relative value units (RVUs) that only address 20 minutes of clinical time based on the minimum amount of non-face-to-face care management time needed to bill for CCM.⁹ This proposal does not account for time spent preparing for this delivery, such as aggregation and review of relevant records, or the costs associated with around the clock needs for vital chronic care. We urge for CMS to account for the expense RVU and malpractice RVU based on the non-face-to-face component of Transitional Care Management (TCM).
- **For purposes of CCM, CMS should appropriately define Rural Health Clinic Services and Federally Qualified Health Center Services.** Under the NPRM, only face-to-face encounters would be eligible for CMS reimbursement to RHCs and FQHCs. However, based on the important role RHCs and FQHCs play in the provision of primary care to Medicare beneficiaries, and because RHCs and FQHCs are not restricted to this requirement in the law,¹⁰ we strongly urge CMS to expand its definitions for RHCs and FQHCs to include CCM to enable this benefit to millions of Americans in areas of need. Alternatively, CMS should make clear in the final PFS that when a RHC or FQHC provides CCM, it may regard that provision as a non-RHC/non-FQHC service that may be billed for separately. Further, CMS should allow RHCs and FQHCs to provide CCM and TCM "incident to" under general supervision.¹¹
- **CMS should provide a model agreement to address CCM recipient beneficiary consent.** To resolve uncertainty related to compliance with requirements for written consent from CCM recipients (and consistent with its previously-used approach¹²) we urge CMS to finalize and publicly release a model CCM recipient beneficiary consent form for use by practitioners.

⁸ *Id.* at 40365.

⁹ *Id.* at Appendix B.

¹⁰ *See* 42 U.S.C. 1395(x)(aa)(1) and (3).

¹¹ CMS proposes that 42 C.F.R. 410.26(b)(5) to read that "[s]ervices and supplies incident to [TCM] and [CCM] services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided by clinical staff." *See* NPRM at 40533.

¹² *See, e.g.,* Form CMS-R-131.

- **CMS should account for remote patient monitoring in the new proposed Healthcare Common Procedure Coding System code.** In finalizing CMS' proposed new Healthcare Common Procedure Coding System (HCPCS) code, we strongly recommend that CMS make a conforming modification regarding CPT code 99091, collection and interpretation of physiologic data, for a 30-day period. This is the most relevant remote monitoring code that has a Medicare RVU greater than 0.00. After the 99091 code was created, CMS unilaterally decided to require that it be "bundled" with other "evaluation and management" services to the Medicare patient. Although coding and rate setting for remote patient monitoring services may ultimately warrant a more comprehensive arrangement, a responsible and realistic step forward at this time would be that the final rulemaking explicitly recognize that 99091 can be used in conjunction with GXXX1.

The undersigned urge your consideration of the consensus of the broad community of stakeholders which support the wide use of telehealth and remote monitoring solutions to improve the United States' healthcare system, and we welcome the opportunity to work with you and your designees moving forward.

Respectfully submitted,

Alere Connect
American Telemedicine Association
ACT | The App Association
Baxter International
Continua Health Alliance
Intel
Panasonic Corporation of North America
Qualcomm
Telecommunications Industry Association