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February 6, 2014

Attention: CMS-1461-P
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: *Multistakeholder Views on the Use of Telehealth and separately,
Remote Patient Monitoring in the Medicare Shared Savings Program,
CMS-1461-P***

Dear Secretary Burwell:

The undersigned organizations write to provide the consensus views across a wide array of stakeholders that you to use your existing authority¹ to waive the current restrictions for telehealth and remote patient monitoring services in the Medicare Shared Savings Program (MSSP). The possibility of a waiver has been raised in the Center for Medicare and Medicaid

¹ 42 U.S.C. § 1395jjj(f) (stating that the Secretary "may waive such requirements of...title XVIII of this Act as may be necessary to carry out the provisions of this section.").

Services' (CMS) Notice of Proposed Rulemaking (NPRM) for MSSP Accountable Care Organizations (ACO) participants, which was released for public input in December of 2014.²

We applaud CMS for including discussion of needed changes to the MSSP that would help realize the potential of telehealth, and believe that its inclusion in the NPRM reinforces CMS as a leader in shaping new ways to integrate and utilize innovative technologies that enable health information and communications technology (ICT) solutions to achieve improved care for Americans at lower costs. Below, we urge CMS' to fully waive the 1834(m) restrictions on telehealth reimbursement, as well as provide separate reimbursement for remote patient monitoring CPT codes³ for all MSSP ACOs. Alternatively for telehealth, should CMS limit its waiver of Section 1834(m) of the Social Security Act,⁴ we urge CMS to waive 1834(m) restrictions for Track 2 and Track 3 ACOs at minimum, also allowing Track 1 ACOs to apply for waivers individually, while gathering evidence from its experiences in the MSSP moving forward towards the incremental expansion of the waiver.

We continue to believe that telehealth and remote patient monitoring solutions hold great promise in reducing inpatient care and readmissions, as well as improving care coordination, but that the use of these technologies is limited by an outdated legal and regulatory structure. CMS' regulations and policies should reflect the dynamic and transformative nature of advanced ICT solutions, and should not stifle innovation that can continually improve patient care. There remains a need for federal priorities to address the full potential of the health ICT ecosystem which is comprised of many technologies, including telehealth and remote patient monitoring. We encourage you to take a technology-neutral approach towards a fully-connected health ICT ecosystem that embraces the diversity of solutions that allow for innovative improvements in care that technology can provide at each stage along the continuum of care. In addition, we urge CMS to ensure flexibility in the how to address risk (including waivers and safe harbors), and for reliance on the adoption of common standards and certification requirements for interoperability.

² Department of Health and Human Services CMS, *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*, 79 FR 72759 (Dec. 8, 2014).

³ For example, while chronic disease remote patient monitoring (CPT code 99091) currently may only be billed when bundled, we believe this code should be unbundled and reimbursed allowing separate payment (approximately \$57.00) to be made to ACO provider/suppliers.

⁴ See 42 CFR § 410.78.

We have long held that the restrictive Medicare definition of telehealth, the section 1834(m) limitations, and separately, the bundling of remote patient monitoring into evaluation and management services, together have resulted in arduous restrictions which limit patient access to new technologies, effectively discouraging providers from utilizing advanced ICT solutions in their practices, including within the MSSP. For example, notable Medicare restrictions include:

- No telehealth services available for about 80% of Medicare beneficiaries who happen to live in the 1200 metropolitan counties not included in the definition of “rural” and not designated as a health professional shortage area;
- No coverage of “store-and-forward” services (such as transmission of medical images) for the 43 million beneficiaries who live outside of Alaska and Hawaii;
- No coverage for telehealth services originating from a beneficiary’s home (even for the “homebound”), an inpatient hospice, or other domicile from which a beneficiary seeks service;
- No coverage for otherwise covered Medicare services of physical therapy, occupational therapy, speech-language pathology, audiology and some other practitioners furnished as telehealth services; and
- No coverage for most health procedure codes furnished as telehealth services, precluding the best judgment of physicians and other practitioners about the medical needs and other circumstances of all Medicare beneficiaries.
- No separate reimbursement for remote patient monitoring due to the designation of CPT code 99091 as a “bundled” service.

Despite the limitations imposed by Medicare, the known benefits of remote patient monitoring and telehealth services include improved care, reduced hospitalizations, avoidance of complications, and improved satisfaction, particularly for the chronically ill.⁵ There are also significant potential for cost savings; for example, remote monitoring is expected to result in savings of \$36 billion globally by 2018, with North America accounting for 75% of those savings.⁶ Providing ACOs with the ability to utilize advanced telehealth and remote patient monitoring solutions is consistent with the goals of the MSSP – namely, improved quality of care and reduced costs. Further, such an approach would be consistent with the Affordable Care Act (ACA) which requires MSSP-participating ACOs to “define processes...to coordinate

⁵ 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>.

⁶ 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.

care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.”⁷

In the NPRM, CMS notes that if a Section 1899(f)-based waiver is used to grant relief of some telehealth restrictions, CMS will likely waive only the originating site requirements in section 1834(m)(4)(C)(i)(I) through (III), and in section 1834(m)(4)(C)(ii)(I) through (VIII).⁸ Further, CMS states that it may also limit waivers to Track 3 ACOs.⁹ CMS makes no reference to the use of the waiver authority to provide separate reimbursement for remote patient monitoring.

As we note above, restrictions on telehealth and remote patient monitoring continue to prevent the realization of virtual care plans available today which would enrich the lives of millions of Americans. Representing a broad cross-section of stakeholders in the healthcare space, we continue to believe that, in order for CMS’ regulations and policies to reflect the dynamic and transformative nature of advanced and innovative ICT solutions available today that has been clearly demonstrated, current telehealth restrictions in section 1834(m) and separately, the bundling requirement for CPT code 99091, should be waived for all MSSP participants. Such an approach would reflect the well-established and growing body of evidence supporting the benefits of telehealth and remote patient monitoring, and would avoid unnecessary limitations on these benefits to millions of Americans.

Alternatively, should it choose to limit its waiver to certain telehealth or remote patient monitoring restrictions or to the type of ACO for which the waiver applies, we strongly urge CMS to continue to carefully collect and review evidence attained from existing and ongoing studies, as well evidence gained in the MSSP itself moving forward, towards incrementally expanding its waiver on these restrictions. Initially, this limited waiver should apply to Track 2 as well as Track 3 ACOs at minimum, as they collectively represent under 5% of all ACOs; further, Track 1 ACOs should also have the ability to apply for a waiver of 1834(m) restrictions and receive separate reimbursement for remote patient monitoring under CPT code 99091. Finally, CMS should also memorialize its intention to, on an annual recurring basis, review data on the benefits of the waiver(s) in place and the ways in which they should be appropriately expanded as part of future MSSP rulemakings.

⁷ 42 U.S.C. § 1395jjj(b)(2)(G).

⁸ NPRM at 72821.

⁹ NPRM at 72817.

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 on such timely actions.

Respectfully submitted,

Alliance for Connected Care
American Telemedicine Association
Baxter Corporation
HIMSS
Intel
Panasonic Corporation of North America
Personal Connected Health Alliance
Qualcomm
Telecommunications Industry Association
Wireless Life Sciences Alliance