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September 11, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-1850

Dear Ms. Verma:

On behalf of the Healthcare Information and Management Systems Society (HIMSS) we are pleased to provide written comments to the Notice of Proposed Rule-Making (NPRM) regarding CMS-1676-P Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program which was published in the Federal Register on July 21, 2017. We appreciate the opportunity to comment on this NPRM, and look forward to continuing to dialogue with the Centers for Medicare and Medicaid Services (CMS) on how to advance our nation's healthcare system toward the goal of value-based care delivery.

HIMSS is a global, cause-based, not-for-profit organization focused on better health through information technology (IT). HIMSS leads efforts to optimize health engagements and care outcomes using information technology. HIMSS North America, a business unit within HIMSS, positively transforms health and healthcare through the best use of information technology in the United States and Canada. As a cause-based non-profit, HIMSS North America provides thought leadership, community building, professional development, public policy, and events. Founded in 1961, HIMSS encompasses more than 68,000 individuals, of which more than two-thirds work in healthcare provider, governmental and not-for-profit organizations across the globe, plus over 630 corporations and 450 not-for-profit partner organizations, that share this cause.

HIMSS applauds CMS for recognizing the value of remote patient monitoring, telehealth services, and other information and communications technology (ICT) enabled services. By soliciting input on how the Medicare program coverage, payment, and reimbursement policies should evolve, CMS has signaled its leadership in accelerating physician adoption of these healthcare delivery modalities that are transforming the practice of medicine.

ICT-enabled care, under the broad term "connected health," is transformative by nature. Connected health systems and services are a foundational component in the transformation of the American healthcare system from its current payment system to one that enables payments based on value and long-term outcomes. Connected health technologies have the ability to break down the traditional barriers of time and space cost-effectively, allowing for "anytime and anywhere" care, and in the process, reduce many burdens imposed on patients and clinicians by current care patterns. As a result, clinicians and caregivers have the tools to be more productive

and deliver higher quality results by addressing patient conditions and unhealthy trends before they develop into costly acute episodes.

HIMSS encourages CMS to embrace a reimbursement system that recognizes the unique characteristics of connected health that enhances the care experience for the patient, providers, and caregivers:

- Collaborative decision-making involving diverse care-teams. Decisions are no longer just between a doctor and patient. Connected technologies allow for the incorporation of a patient's family and trusted advisors, as well as other allied health professionals, in the decision-making process.
- Expanded care locations and always-on monitoring. When patients are always connected, care (the interpretation of data and decision support) can occur at any time and in any place.
- A reliance on technology, connectivity, and devices. Connected health involves communication systems using a variety of components; these may be managed by the provider, the patient, or other parties in the care team.
- Empowerment tools and trackers that enable patients to become active members of the care continuum outside of the hospital setting, and promote long-term engagement which, in turn, leads to a healthier population.

Any reimbursement system must be designed to incent the increased use of connected health technologies by participating Medicare healthcare professionals. Medicare patients should have the advantage of utilizing technologies that allow them more time away from healthcare facilities, proactive control of their care, improved access to their records and health data, and the tools that make that data come alive. A constraining system risks stifling innovation and enabling information blocking. Such negative outcomes occur by limiting the adoption of new technologies, and offering protection to a few incumbent market participants.

Many organizations have been working thoughtfully on specific proposals and updates to current reimbursement models. HIMSS strongly recommends that CMS work with a wide array of stakeholders to incorporate ideas into a new payment paradigm that will support the shift to value based care models. Specifically, we recommend incorporating the work of the American Medical Association's Digital Medical Payment Advisory Group through a broadened set of CPT codes for remote patient monitoring connected health services.

Please accept our specific comments in response to CMS's 2018 proposed physician fee schedule:

Medicare Telehealth Services

HIMSS encourages CMS to promulgate a precise definition of what service characteristics fit within the statutory definition of telehealth. We further ask CMS to consider applying waivers as broadly as is legally permissible on statutory and regulatory restrictions related to telehealth (i.e., waivers on originating site restrictions and geographic areas where telehealth services are allowed). We propose that this definition include services with these characteristics:

- Require synchronous communication between provider and patient;
- Enabled via voice and/or video communication; and,
- Require the presence of one or both parties in a healthcare facility.

As clearly stated by CMS, it is important to note that other virtual care enabling technologies are not subject to the telehealth geographic and site restrictions: "We note that remote patient monitoring services would generally not be considered Medicare telehealth services as defined under section 1834(m) of the Act. Rather, like the interpretation by a physician of an actual electrocardiogram or electroencephalogram tracing that has been transmitted electronically, these services involve the interpretation of medical information without a direct interaction between the practitioner and beneficiary. As such, they are paid under the same conditions as in-person physicians' services with no additional requirements regarding permissible originating sites or use of the telehealth place of service code." HIMSS agrees and recommends, as outlined below, CMS strive to expand the array of such covered services:

Remote Patient Monitoring

For remote patient monitoring and other connected health technologies, CMS has significant discretion to expand coverage to enable the delivery of virtual care. We urge CMS to consider these flexibilities and accept the growing available evidence-based studies that support useful, coordinated, high-quality, virtual digital clinical care.

CPT code 99091 is a welcome, but imperfect, start to enabling reimbursement for remote patient monitoring services. The current definition has two main flaws: it assumes episodic evaluation of data around the time of a visit, and does not specifically refer to remotely acquired patient data. HIMSS recommends that CMS create a new code, unique to remotely acquired patient-generated health data (PGHD). Further, HIMSS recommends that CMS use this code for paying for remote patient monitoring services that occur over a defined period, rather than for services tied to a particular episode of care. The true power of connected health to transform care delivery and improve health outcomes lies within its value as an early warning system for impending problems; not a diagnostic tool for existing ones. Connected care technologies enable care professionals to interpret clinical information without direct interaction. Therefore, a properly functioning reimbursement program supports frequent assessments of patient vital signs and other symptoms. For example, a blood glucose monitoring program can use the services of a diabetes educator to review a patient's uploaded blood sugar values several times a week; this educator can, if high readings are found, intervene with a phone call to the patient. Another example are nurses using a heart failure monitoring program to review patients' vital signs every morning; nurses can provide either – or both – patient education or rapid adjustments to medication if an out-of-range value is detected. These programs, and a multitude of others, focus on correcting problems *before* a Medicare patient drifts outside of normal values, *before* a visit when the window for making simple corrections to medication, diet, or lifestyle may have already passed.

We recommend CMS consider immediately issuing temporary G-Codes similar to those being proposed by the AMA Digital Payment Advisory Group (DMPAG) for consideration at the

September 2017 meeting of the CPT Editorial Panel. In short, AMA is contemplating the creation of the following codes:

- Chronic Care Remote Physiologic Monitoring (Professional Component)
  - Code to report the physician/provider services of chronic care monitoring/management of a patient using remote monitoring technology. It is for Physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
- Chronic Care Remote Physiologic Monitoring (Technical Component and Set Up)
  - Codes to report the technical component of monitoring/management for chronic care patients with remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate); set-up and patient education on use of device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.

Other chronic care management CPT codes such as 99487 and 99490 include requirements such as the use of a certified electronic health record, continuity of care, enhanced communication, a significant risk of death of the patient, and ties to a comprehensive care plan. Like 99091, these codes are not specific to using remotely acquired PGHD, and they are clearly targeting patients who are already in serious decline with complex care needs. To harness the preventive power of RPM and delay costly declines from emerging chronic conditions, HIMSS urges CMS work with the AMA to create RPM-specific codes that target patients with less complex needs.

Although CPT Codes 99090 and 99091 are incomplete for purposes of adequately describing remote patient monitoring services, we appreciate CMS's interest to unbundle both codes and make separate payments on each. Today, 99090 and 99091 are bundled miscellaneous codes; mainly, they exist to report adjunct services that are not bundled, covered and paid. Furthermore, under 99091, if the services described are provided on the same day a patient presents for an evaluation and management service, the services under 99091 are considered part of the evaluation and management and not separately reported. 99090 has no assigned valuation, whereas 99091 does. We recommend CMS carefully evaluate both codes on their merits, unbundle each, cover, price and pay them as applicable.

While ample evidence shows that connected health programs can reduce costs and increase patient and provider satisfaction, successful deployment of these programs requires more than just interactions between Medicare beneficiaries and healthcare providers. Successful RPM programs require the deployment and management of home-based medical devices and communications equipment. It is also vital to provide meaningful technologies to patients that go beyond simple access to health data. These patient-facing technologies lead to more engaged and activated patients through tools such as health journals, surveys, alerts and reminders, charts and graphs, self-management action plans, and educational materials. Physicians and healthcare practices can incur significant expenses trying to acquire, distribute, manage and train staff and patients on the use of this equipment, and we urge CMS to work with stakeholders to help providers mitigate these additional costs to encourage more use of connected health technology.

This effort should support, and be in harmony with, incentives offered under the Quality Payment Program, and incent even non MIPS-eligible clinicians to adopt connected technologies.

Medicare Diabetes Prevention Program

To test and evaluate aspects of virtual sessions related to the Diabetes Prevention Program, HIMSS supports the creation of a separate model under CMS's Innovation Center. CMS is considering a separate model under CMMI to test and evaluate virtual DPP services that would run parallel to the MDPP Expanded Model. The MDPP Expanded Model primarily aims to offer participants in-person DPP services, but allows a limited number of virtual makeup sessions on an individual basis. The original DPP model test used to make the statutorily required determination for expansion did not include virtual DPP services.

CMS has stated that there is substantial research on the effectiveness of DPP furnished virtually, and emerging evidence on DPP delivered virtually suggests that virtual delivery can show similarly successful participant weight loss and health benefits to DPP provided in other settings, including among Medicare-age participants. CMS states it will be releasing details on the model test for virtual DPP services separately. We look forward to learning what CMS has in mind for this new CMMI DPP test. HIMSS recommends that, for the test, CMS maximize virtual DPP services. We urge CMS, where applicable and supported by evidence, to make virtual services available to Medicare recipients via any modality or technology.

We welcome the opportunity to meet with you and your team to discuss our comments in more depth. Please feel free to contact Eli Fleet, Director of Federal Affairs, at 703.562.8834, with questions or for more information.

Thank you for your consideration.

Sincerely,

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