



April 1, 2019

The Honorable Mike Thompson
United States House of Representatives
Washington, D.C. 205105

The Honorable Peter Welch
United States House of Representatives
Washington, D.C. 20515

The Honorable David Schweikert
United States House of Representatives
Washington, D.C. 205105

The Honorable Bill Johnson
United States House of Representatives
Washington, D.C. 20515

The Honorable Brian Schatz
United States Senate
Washington, D.C. 20510

The Honorable Roger Wicker
United States Senate
Washington, D.C. 20510

The Honorable John Thune
United States Senate
Washington, D.C. 20510

The Honorable Benjamin Cardin
United States Senate
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
Washington, D.C. 20510

The Honorable Cindy Hyde-Smith
United States Senate
Washington, D.C. 20510

Dear Representatives Thompson, Welch, Schweikert, and Johnson, and Senators Schatz, Wicker, Thune, Cardin, Warner, and Hyde-Smith:

On behalf of the Healthcare Information and Management Systems Society (HIMSS) and the Personal Connected Health Alliance (PCHAlliance), we appreciate this opportunity to provide feedback as you begin your work crafting comprehensive telehealth legislation for the 116th Congress. We thank you for your continued leadership in issuing this bipartisan, bicameral request for input from the stakeholder community. We share your goal of creating a robust environment/ecosystem that supports, not inhibits, the greater utilization of evidenced-based connected health technology, particularly in the Medicare program.

2018 marked a significant year for the advancement of telehealth and remote patient monitoring policy, with the passage of the Bipartisan Budget Act of 2018 (H.R 1892) and the SUPPORT for Patients and Communities Act (H.R. 6), coupled with the reforms enacted under the 2019 Medicare Physician Fee Schedule and Quality Payment Program rules and Home Health Prospective Payment System rules. Connected health technologies continue to transform care delivery for Medicare beneficiaries by expanding access to high-quality care, while lowering costs and resulting in better overall value for patients and the Medicare program, particularly in underserved communities (both urban and rural), for those with chronic conditions or who are

homebound. However, significant barriers and challenges still exist that can be overcome with enactment of legislative provisions.

The connected health revolution, fueled by the adoption of telehealth, remote monitoring and other health information and technology, requires reliable broadband connectivity and the ability to accurately collect medical data from multiple systems and devices. Yet there continues to be a significant disparity across America, with many patients and providers in rural and underserved areas still lacking access to affordable, quality broadband. We've heard from our members of about a general lack of awareness concerning the existence and availability of these new technologies and their many benefits. A greater familiarity with telehealth and remote monitoring may lead to ease of use and improved utilization as the patients increase their familiarity with connected health. An education or outreach campaign may be necessary to best stimulate adoption and incentivize greater patient, provider, and caregiver engagement.

Despite these and other policy obstacles, we have the unique opportunity before us to enact laws to modernize healthcare delivery, particularly as they relate to the Medicare program, by reducing or eliminating the barriers that have long inhibited greater adoption of the life-changing technologies. To that end, we look forward to building on the progress from 2018 and offer the following recommendations for telehealth legislation to be considered in the 116th Congress:

Several CONNECT for Health Act of 2017 Provisions (not enacted in the 115th Congress) are important to advancing evidence based connected care, they include:

Section 7: Adding rural health clinics and Federally qualified health centers as Medicare originating and distant sites, regardless of geographic location

This is an important, commonsense provision, and we support its inclusion in any legislation.

Section 8: Allowing Native American Health Service facilities to serve as eligible originating sites for Medicare telehealth reimbursement

This is an important, commonsense provision, and we support its inclusion in any legislation.

Section 10: Allowing telehealth services to be included in bundled or global payments without restriction, e.g. no application of Section 1834(m).

Please note that this section of the 115th Congress' CONNECT for Health Act included "remote monitoring", which we feel no longer needs to be included. As of January 2019, CMS policy covers remote physiologic monitoring in the 2019 Medicare Physician Fee schedule. It is now included as a Part B covered service for patients with a chronic condition and may now be included in bundled or global payments.

Section 11: Expanding the use of telehealth through the waiver of certain requirements.

Please note this is a key provision to modernization of Medicare and we ask one change in this section:

Remove the provision requiring the Office of the Actuary certify cost impact as neutral or cost savings: specifically we request removal of “(ii) The Chief Actuary of the Centers for Medicare and Medicaid Services certifies that such waiver would reduce (or would not result in any increase in) net program spending.

We believe this provision is duplicative of the secretarial determination requirements for the waiver and the claims experience from the new 2019 Medicare Physician Fee Schedule (MPFS) codes on virtual visits and remote physiologic monitoring which may provide the information needed for scoring and designing a value-based benefit.

Section 12: Expanding use of telehealth services for mental health

This application of telehealth services is well supported in the clinical research literature and is essential to addressing service shortages.

Section 14: Testing of models to examine the use of telehealth and remote monitoring under the Medicare program

We urge inclusion of this provision as an important tool for development of evidence based innovation.

The following are new provisions for Telehealth legislation we recommend. We outline the proposal and the rationale for the change along with a brief statement of supporting evidence. We are happy to provide more detail on any of these recommended telehealth legislative provisions.

Proposal 1: Permit Secretary to waive 1834(m) restrictions for delivery of care to Medicare beneficiaries to: 1) provide care that addresses a public health emergency; and, 2) during natural disasters.

Rationale: Access to care is an essential barrier to addressing public health crises and maintaining health in the wake of a natural disaster. Delivery of care through digital means – including the full range of synchronous and asynchronous communications – offers a cost effective means to getting essential services, identifying health needs and planning to address those needs. A waiver of Medicare’s telehealth originating site, geographic, and modality restrictions would permit a broad and flexible range of information and communications technology methods for connecting health care providers with patients needing immediate access to care under unique circumstances.

Supporting Evidence: Remote patient monitoring, using common international standards like the Continua Design Guidelines, were deployed in Japan after the Tsunami in 2011 to maintain and continue treatment for those with high blood pressure who were displaced. The remote monitoring of 341 hypertensive patients' home blood pressure data by attending clinicians continued for four years after the natural disaster. [Comprehensive results and feasibility analyses](#) were published on the U.S. National Library of Medicine National Center for Biotechnology Information website.

In addition, [a use case on use of ICT based care for delivery of care after a natural disaster](#) is available on the Personal Connected Health Alliance website.

Proposal 2: Waiver of the cost sharing (i.e. copayment requirements) for digitally stored data services and remote physiologic monitoring and treatment management services typically required under Medicare Part B. These physician ordered and supervised services are covered by Medicare as of January 2019. CPT codes under this category include: 99091, 99453; 99454; and 99457.

Rationale: Uptake and use of digitally stored data services and remote physiologic monitoring for those with a chronic condition is very low and requires billing of monthly copayment which may be a barrier to patient uptake. Yet, these care management services are associated with reduced hospitalization rates, reduced emergency department visits, and better outcomes. Waiver of the copayment would ease adoption and increase the use of digitally stored data services and remote physiologic monitoring, and can only be accomplished through a statutory change.

Supporting Evidence: The Medicare 2019 Physician Fee Schedule rule outlined an excellent case for use of remote physiologic monitoring as a means to improve care, and reduce hospitalizations and emergency department visits.

Proposal 3: Authorize the Secretary to establish connected health preventive health benefits for United States Preventive Services Task Force (USPSTF) A or B rated services that can be delivered through digital technologies and platforms. These include [Intensive behavioral counseling for healthy lifestyle for those with obesity or overweight with CVD risk factor or abnormal blood glucose; and, home based blood pressure monitoring to diagnose high blood pressure]

Rationale: Several important USPSTF A or B rated services rely upon home based connected care or virtual/online service delivery as a core component of the evidence base. The USPSTF found adequate evidence to support home based blood pressure monitoring, yet Medicare does not cover home-based blood pressure monitoring and instead covers a more burdensome and costly approach for diagnosis of high blood pressure. Giving the Secretary authority to establish connected health benefits for this USPSTF recommendation would modernize Medicare in a manner that aligns coverage with the evidence and expert recommendations.

For CVD Risk Reduction, Prevention of Weight Related Chronic Conditions, and Prevention of Diabetes: Intensive behavioral counseling for healthy lifestyle is a lynchpin service for effective treatment of obesity and those with overweight. The service is recommended by the USPSTF as well as professional societies. USPSTF and other expert panels have identified the key elements of intensive behavioral counseling associated with prevention of CVD and weight related conditions and efficacy when delivered by digital platforms or online programs is well documented.

Supporting Evidence: CDC recognizes and tracks the efficacy of digital and online programs through its National Diabetes Recognition Program (NDPR). This is a well-defined, extensively researched, efficacious intervention for those with high CVD risk, obesity, or prediabetes. In addition, the published literature is extensive on digital, virtual and online delivery of behavioral counseling for healthy lifestyle and helped USPSTF established clear standards for what comprises an effective program.

Proposal 4: Modify the Medicare Durable Medical Equipment (DME) benefit to eliminate the requirement that no part used in the DME can be ‘general use’, e.g. permit personal smart phones or personal computers to collect data and organize device data or act as the device receiver, and exclude the personal device from reimbursement/valuation for the DME when it is used as the device receiver.

Rationale: Currently, DME with a digital component, such as a continuous glucose monitor, can only be covered if it is manufactured with a dedicated receiver used solely for data collection, storage, and transmission from the device even though a smart phone or personal computer could serve as a receiver for data collection, storage, and transmission. This modification would allow CMS to cover the medical equipment portion, even when it is not manufactured with a dedicated receiver, and allow a beneficiary to use their personal phone or computer as their receiver (which Medicare would not reimburse). This would align the DME definition better with today’s technology AND would eliminate the Medicare program requirement that manufacturers produce and sell a stand alone receiver which adds costs to the DME that for many Medicare beneficiaries is unnecessary.

Supporting Evidence: This is a common-sense change.

Proposal 5: Amend Balanced Budget Act of 2018 provision that permitted Medicare Advantage plans to use telehealth and RPM and virtual visits, so that technology enabled services can be a means to meet network adequacy in disparate areas with low population density.

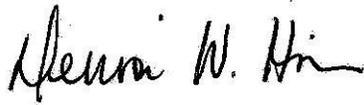
Rationale: Network adequacy cannot be met in rural disparate areas with low population density and this prohibits the development and offering of Medicare Advantage plans at all. Yet, in these areas the fee for service traditional provider system simply does not exist and a virtual or telehealth network would provide improved access to providers. Medicare Advantage is permitted to provide telehealth and other innovative approaches

to deliver care and could provide improved care access for rural disparate areas with low populations density where no providers reside or practice.

Supporting Evidence: This is a common-sense change.

Again, thank you for the opportunity to provide feedback. We look forward to continuing to work with you and your offices to modernize the Medicare program through sound evidence-based telehealth and remote monitoring policy. If you have questions, or would like additional information, please contact Samantha Burch, HIMSS Senior Director of Congressional Affairs, at sbburch@himss.org or 703-562-8847 or Jody Hoffman, Policy Consultant for PCHAlliance at Jody@RepublicConsulting.com or 202-341-1779.

Sincerely,



Denise W. Hines, DHA, PMP, FHIMSS
Chief Americas Officer
HIMSS



Steve Wretling
Chief Technology and Innovation Officer
HIMSS (on behalf of PCHAlliance)