



August 31, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Docket Number CMS-1689-P

Submitted Electronically to www.regulations.gov

Dear Administrator Verma:

We appreciate the opportunity to provide comments on the “Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations” proposed rule. Our comments focus on the provisions of the Home Health Prospective Payment System and Home Infusion Therapy Requirements that incorporate patient centered connected care.

Interoperable, connected health, requires and includes a broad echo-system of shared digital health information and use of digital health information. It is particularly noteworthy that this proposed rule takes an enormous and important step forward to advance digital, interoperable, connected health care. ***We extend our appreciation for incorporation of evidence based remote patient monitoring to support and assist in the conduct of care planning and for the inclusion of remote monitoring as an essential component to home infusion therapy.***

Specifically, we want to express our support for:

- The inclusion of the costs of remote patient monitoring to assist and support care planning as an allowable administrative cost. And, we note published research examining the impact of a remote monitoring intervention for Medicare Home Health patients showing substantial reduction in hospitalization rates which provides clear evidence to support this policy change.ⁱ
- The inclusion of remote monitoring, through telephone or other electronic communication based on patient preference, as a required home infusion therapy service in proposed Section 486.535. Remote monitoring is both a viable and clinically proven means to conduct monitoring. We note that there is extensive literature on the efficacy and value of remote monitoring to staff intensive care units^{ii, iii, iv}.

With regards to the proposed definition of remote patient monitoring (RPM) for home health, we recommend CMS adopt a definition aligned with the new evidence-based Code Procedural Terminology (CPT) codes created in January by the American Medical Association CPT Editorial Panel for remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate). These include the initial set-up and patient education on use of equipment (CPT 990X0) and remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days (CPT 990X1).^v Use of these two codes for the definition of RPM would align well with CMS home health reimbursement policy to include the costs of the remote monitoring equipment and data capture for care planning (which is already covered) as these two codes are expressly limited to: 1) patient education with set up of remote monitoring; and, 2) the remote monitoring equipment supply and data collection. In addition, we note that defining remote patient monitoring in alignment with CPT Codes 990X0 and 990X1 ensures a technology and modality neutral approach to remote patient monitoring. Further, CMS proposes to exclude interpretation of the physiologic data, and these two codes were defined in a manner that excludes interpretation. The professional time spent on interpretation of data is defined by CPT codes 99091 and 994X9.

We believe that use of the new codes, CPT 990X0 and 990X1, which are specifically defined in a manner that aligns with CMS policy would be preferable to modifying the CPT code that was created to cover licensed professional interpretation of physiologic data.

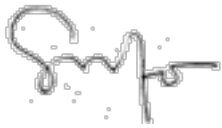
Digital health is a broad ecosystem of health information technologies including remote patient monitoring that leverage mobile medical devices (as defined by the Food and Drug Administration) that are used as necessary based on individual beneficiaries, their medical conditions and disease needs. It is important to note that CMS made an important and well-reasoned policy declaration in the 2018 Physician Fee Schedule, stating that

As has long been the case, certain other kinds of services that are furnished remotely using communications technology are not considered “Medicare telehealth services” and are not subject to the restrictions articulated in section 1834(m) of the Act. This is

We agree and encourage CMS allow for the broad utilization of digital health medical technologies (which include medical telecommunication technologies) in healthcare service delivery in home health care, clinical services, and hospital care. We would welcome the opportunity to engage CMS for further discussions and considerations in future rulemaking on available innovative medical technologies.

Personal Connected Health Alliance (PCHA) extends its support for these new and welcome incentives and standards that promote adoption of evidence based connected care in home health care and home infusion therapy. And, CMS' citation of a part of the extensive and growing body of clinical evidence supporting the use of remote access technology (including telemonitoring and remote patient monitoring) – to conduct disease/care management and planning was truly heartening. Please continue to work with PCHA and its respective members on ensuring improved communication and exchange of health information between providers and health consumers. Thank you

Sincerely,



Richard M. Scarfo

Vice President

Personal Connected Health Alliance

ⁱ Chen HF, Kalish MC, Pagan JA. Telehealth and hospitalizations for Medicare home healthcare patients. Am J Manag Care. 2011 Jun 1;17(6 Spec No.):e224-30. Accessed at: <https://www.ncbi.nlm.nih.gov/pubmed/21756016>

ⁱⁱ Hassan E. Tele-ICU and Patient Safety Considerations. Crit Care Nurs Q. 2018 Jan/Mar;41(1):47-59. Accessed at: <https://www.ncbi.nlm.nih.gov/pubmed/29210766>

ⁱⁱⁱ Kolls BJ, Mace BE, Dombrowski KE. Implementation of Continuous Video-Electroencephalography at a Community Hospital Enhances Care and Reduces Costs. Neurocrit Care. 2018 Apr;28(2):229-238. Accessed at: <https://www.ncbi.nlm.nih.gov/pubmed/29067633>

^{iv} Kalb T, Raikhelkar J, Meyer S, Ntimba F, Thuli J, Gorman MJ, Kopec I, Scurlock C. A multicenter population-based effectiveness study of teleintensive care unit-directed ventilator rounds demonstrating improved adherence to a protective lung strategy, decreased ventilator duration, and decreased intensive care unit mortality. J Crit Care. 2014 Aug;29(4):691.e7-14. Accessed at: <https://www.ncbi.nlm.nih.gov/pubmed/24636928>

^v See: Newly Released Codes, September 2017 CPT Editorial Summary of Panel Actions, accessed at: <https://www.ama-assn.org/sites/default/files/media-browser/public/physicians/cpt/september-2017-summary-panel-actions.pdf>. Last visited August 21, 2018.