September 16, 2019

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, District of Columbia 20201

RE: *Multi-stakeholder Comments to the Centers for Medicare and Medicaid Services on* Medicare Program: CY2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc. (CMS-1715-P)

We represent a diverse coalition of stakeholders that span the healthcare and technology sectors, all of whom support the expanded use of connected health technologies in healthcare. A consistently growing body of evidence demonstrates that connected health technologies improve patient care, reduce hospitalizations, help avoid complications, and improve patient engagement (particularly for the chronically ill). These tools, increasingly powered by artificial/augmented intelligence (AI), leverage patient-generated health data (PGHD) and range from wireless health products, mobile medical devices, telehealth and preventive services, clinical decision support, chronic care management, and cloud-based patient portals. It is essential that these tools be utilized to address the rising costs of healthcare to both the public and private sector, and we appreciate the opportunity to provide our comments on the Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule for calendar year (CY) 2020.[1]

We support CMS' activation of the Current Procedural Terminology (CPT®) codes developed to report remote physiologic monitoring (RPM) services (99091, 99453, 99454, and 99457). However, we disagree with CMS' proposal to reduce the practice expense of code 99453 from 0.54 wRVW in CY2019 to 0.52 wRVW in CY2020, and to reduce the practice expense of code 99454 from 1.77 in CY2019 to 1.71 in CY2020. As CMS has not provided any rationale as to a change in equipment, supplies, or staff which would justify a reduction in practice expense, we strongly encourage CMS to maintain the existing practice expense for these codes in CY2020. We encourage CMS to develop sub-regulatory guidance on the use of RPM in Medicare, which CMS committed to develop in the PFS Final Rule for CY2019.

We support CMS' proposal to activate and pay for CPT code 994X0, which will account for an additional 20 minutes in a calendar month of RPM treatment management services by clinical staff, a physician, or other qualified health care professional (QHCP). However, we disagree with CMS' proposal to value this additional 20 minutes of RPM review at an RVU lower than that for the same service for the first 20 minutes in the same calendar month (99457). CMS'

[1] Centers for Medicare and Medicaid Services, *Medicare Program; Medicare Program: CY2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc.CY2*, 84 FR 40482 (Aug. 14, 2019).

rationale, using an analogy to code 88381, is insufficient and does not provide an acceptable explanation as to why review of RPM by the physician, QHCP, or clinical staff is less valuable after the first 20 minutes aggregate. First, the additional 20 minutes of analysis is likely to be furnished to patients who have a need for deeper analysis of their RPM data, making the service as valuable as the same service for the first 20 minutes that month. Second, with more data points and analysis of such data points providing even greater insight into health trends for a patient, analysis done in the additional 20 minutes is at least as valuable as the first 20 minutes. We recommend that CMS adopt the RUC-recommended RVU of 0.61.

We strongly support CMS' proposal that codes 99457 and 994X0 may be furnished under general supervision, rather than direct supervision. We appreciate CMS' technical correction made earlier in 2019 to clarify that auxiliary staff may furnish the 99457 service, and for collaborative discussion throughout this year about further steps needed to realize the full potential of remote physiologic monitoring tools and services. CMS' proposed clarification is necessary to realize this potential.

With respect to the QPP, we note that with the passage of Medicare and CHIP Reauthorization Act of 2015, Congress has directed CMS to evolve the Medicare program to maximize care quality over quantity, requiring the system to embrace the enhancements that connected health technology offers. Through the CY2020 QPP rulemaking, CMS has an excellent opportunity to advance the American healthcare system through the leveraging of a wide array of connected health technologies, both those available today as well as emerging technology innovations. CMS is encouraged to continue to incentivize the flexible and scalable use of connected health technology throughout the Merit-based Incentive Payment System (MIPS). CMS should also avoid overburdensome MIPS Promoting Interoperability program compliance and reporting requirements in order to avoid technology-specific mandates and to alleviate provider burnout related to electronic health record use. Further, CMS should explicitly endorse the use of connected health technologies' role in the success of Alternative Payment Models (APMs). We urge CMS to utilize every opportunity available to move away from legacy measurement programs and towards a truly connected continuum of care through its implementation of the QPP.

Finally, regarding program integrity risks across the PFS and QPP, we note our support for measures to avoid waste, fraud and abuse. The use of new technology modalities (whether Medicare telehealth services or remote communications technologies) does not inherently translate to greater waste, fraud and abuse; to the contrary, program integrity is more easily ensured through real-time data analytics that greater use of connected health technologies provide. We therefore urge CMS to embrace connected health technologies and to utilize the ability of these technologies to avoid and prevent programmatic waste.

We appreciate CMS' consideration of our input on the proposed PFS and QPP rule for CY2020, and for its proposals to leverage the incredible potential of remote patient monitoring technologies. We encourage CMS' thoughtful consideration of the above input and stand ready to assist further in any way that we can.

Sincerely,

AliveCor

Alliance for Connected Care

American Association for Respiratory Care

American Telemedicine Association

Biocom – Life Science Association of California

Catalia Health

Connected Health Initiative

Diasyst

HIMSS

Kaia

Life365

LifeWire

Personal Connected Health Alliance (PCHAlliance)

Pt Pal

Rimidi

UnaliWear

Upside Health