ALLIANCE for CONNECTED CARE

TO: Joe Grogan

FR: Alliance for Connected Care

DATE: June 12, 2017

RE: Telehealth and Remote Monitoring

Background:

Telehealth consists of real-time, face-to-face visits between providers and their patients. Remote patient monitoring is the asynchronous monitoring of biometric data by providers. While both are remote technologies, they are regulated differently. For telehealth, Section 1834(m) of the Social Security Act (42 U.S.C. 1395m) restricts utilization of and reimbursement for telehealth and remote patient monitoring services in the traditional Medicare fee-for-service (FFS) program by narrowly defining conditions around eligibility for coverage. A primary limitation is the originating site restriction, which requires the patient receiving the telehealth service to be in a rural area and be in a facility to qualify for Medicare coverage. This statutory restriction has made telehealth almost non-existent in Medicare FFS. Remote monitoring is hindered by definitions and heavy regulation around Chronic Care Codes.

The impact of Section 1834(m) restrictions and lack of coverage for remote monitoring is far-reaching, including:

- No telehealth coverage for about 80% of Medicare beneficiaries who live in the 1,200 metropolitan counties not included in the definition of "rural."
- No coverage for "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 services originating from a beneficiary's home (even for the "homebound"), a hospice and other common non-medical locations from which a beneficiary seeks service.
- No coverage for most health procedure codes, precluding the best judgment of physicians and other practitioners about the medical needs and other circumstances of all Medicare beneficiaries.
- No coverage for otherwise covered Medicare services of physical therapy, occupational therapy, speech-language pathology, audiology and some other practitioners.
- Virtually non-existent remote patient monitoring.

Discussion Topics:

1) The Alliance, along with many other stakeholders, is supporting a two-part amendment to the Medicare extender package in Congress. The first part of the legislative language provides the Secretary of HHS the authority to waive 1834(m) restrictions if the CMS Actuary deems that the services save money or improve quality. The second part of the amendment adds remote monitoring to Medicare Advantage. Existing provisions in the CHRONIC Act, which has already

passed out of the Finance Committee, only adds telehealth. We support adding remote monitoring as well. It would be very helpful if your office could weigh in with the Finance Committee in support of these legislative changes.

2) If Congress is successful in adding telehealth to the basic benefit of MA, we encourage CMS to remove the Part B enrollment requirement for physicians/licensed professionals ("Provider") rendering the services. This action would eliminate a duplicative barrier to access that requires physicians/licensed professionals to be subject to credentialing and oversight of the Medicare Advantage plans and be enrolled as Medicare providers.

3) CMS has authority under 1899(f) of the ACA to waive telehealth restrictions for ACOs. We strongly support the use of this authority and hope you will consider exercising it to allow ACOs to be reimbursed for telehealth.

4) CMS can update the MA network adequacy exception criteria to include considerations of telehealth. Right now, CMS requires that MA plans meet network adequacy requirements based on time and distance standards, with some super limited exceptions—notably, CMS does not allow plans to meet network adequacy using telehealth services, even if those services are commonly used, or can improve beneficiary access, outcomes, etc. The rules should be modified so that, where appropriate, use of telehealth can count towards network adequacy or (at the very least) telehealth can be used in exceptions situations. The National Association of Insurance Commissioners is on record stating that telehealth can help meet network adequacy requirements.

5) CMS has existing authority to provide adequate reimbursement for collection and interpretation of physiologic data stored/transmitted by patient/caregiver by "unbundling" the relevant Current Procedural Terminology (CPT®) codes 99091 and 99090. Such a practice would align with CMS' established approach to chronic care management where, the challenges of preventing and managing chronic disease caused "the focus of primary care [to evolve] from an episodic treatment-based orientation to a focus on comprehensive patient-centered care management."

6) The American Medical Association has established a digital advisory committee that will create five new remote monitoring CPT codes in October. We strongly encourage CMS to create G-codes based on these CPT codes so patients and providers can access these services immediately rather than waiting for the physician fee schedule process.

Meeting Participants

John Jesser, CEO, LiveHealthOnline, Anthem

John F. Jesser serves as CEO of LiveHealthOnline and the vice president of Provider Engagement Strategy for Anthem, Inc., the nation's largest health benefits company. In this capacity, Mr. Jesser manages a company-wide process that looks at healthcare-related functions to improve the affordability of health care; the consumer experience and access to care. He leads the company's telehealth strategy as the president of LiveHealth Online, an online care solution for consumers and providers being offered to Anthem's customers. Mr. Jesser focuses on solutions and digital tools that improve the connection between doctors, hospitals, consumers and health plans. Previously, he served for more than 24 years in

various management positions within the healthcare field. Mr. Jesser earned his B.S. in mass communications from Miami University in Oxford, Ohio and an MBA from Cleveland State University. He serves as chairman of the board of managers for Availity, LLC, a company that provides connectivity between healthcare payers and providers; and is chairman of the board of National TeleHealth Network (NTN), a telehealth physician management company founded as a joint venture between American Well and Anthem.

Randy Swanson, CEO, Care Innovations (an Intel Company)
Randy Swanson is the Chief Executive Officer of Care Innovations®. He has responsibility for corporate business strategy, innovation-centered research and program development, partner engagements, finance, quality, product operations, and human resources. In addition, he has executive-level responsibility for Corporate Compliance. Most recently, he was the Vice President, Chief Innovation Officer, focused on business strategy and innovation growth. As a 17-year Intel veteran, Randy has held a variety of finance and business development positions across numerous business groups at Intel, including Digital Health Group, New Business Group, Intel Architecture Group, and the Technology & Manufacturing Group. Randy most recently served as Controller and Director of Business Development in the Digital Health Group. Randy received a Bachelor of Science in Electrical Engineering at Clarkson University, a Masters in Business Administration at Michigan Business School, and a Masters of Systems Engineering at the University of Michigan.

Mike Baird, CEO, Avizia
Mike Baird is the Chief Executive Officer and Founder at Avizia. Mike founded Avizia with a mission to improve patient outcomes and expand the reach of healthcare through technology. As a parent of five kids, he has interacted with hospitals, emergency rooms, and physicians on a regular basis and thinks we can do better. A passionate technologist, Mike is constantly looking for ways to take cutting edge technology and make it affordable, approachable, and easy to use. Prior to Avizia, Mike held senior positions leading strategy, marketing, and product development teams at Tandberg, Cisco, McKinsey & Co, and Dell. Mike holds an MBA with distinction from the Kellogg School of Management at Northwestern University and was designated in 2005 as a Siebel Scholar.

Scott Decker, CEO, MD Live
Mr. Scott D. Decker serves as the CEO of MDLIVE, where he leads MDLIVE's mission to develop the solutions to help consumers, employers, health plans and health systems to improve health and wellness outcomes performance while reducing costs. Prior to MDLIVE, Mr. Decker's successful roles include President of HealthSparq, President of NextGen Healthcare Information Systems Inc, founder and CEO & President of Healthvision. VP of Development at VHA Inc.'s Health Information Technologies business unit, and CEO of U.S. Carelink. He is honored twice as a finalist for the Ernst & Young Entrepreneur of the Year. Mr. Decker summa cum laude from Trinity University in San Antonio, Texas, where he earned a bachelor's degree in computer science.

Ralph Derrickson, CEO, Carena
Since joining Carena as President and CEO in 2006, Ralph has overseen the company's transformation from a house call company to a virtual healthcare solutions provider with care-quality as the core of its vision. Ralph's leadership includes investment in clinical quality and partnerships with leading health systems and Fortune 50 companies to offer high-quality virtual care access to over 18 million consumers. Prior to Carena, Ralph served as Managing Director of Venture Investments at Vulcan Capital, where he was responsible for the firm's technology and biotechnology investments. He co-founded Watershed Capital, an early stage technology venture fund. Ralph has served on the boards of

numerous technology start-ups and has held leadership positions at Starwave Corporation, NeXT Computer, Inc., and Sun Microsystems. Ralph earned a degree in systems software science from the Rochester Institute of Technology.

Julie Barnes, Vice President, Cambia Health Solutions
As director of Health Care Policy, Julie Barnes advances Cambia Health Solution's legislative, regulatory, and investment efforts to promote a more affordable, transparent, and sustainable health care system. Cambia, headquartered in Portland, Oregon, is a growing family of companies ranging from software and mobile applications to non-traditional health care delivery models, health insurance, pharmacy benefit management, wellness, and overall consumer engagement. Prior to her role with Cambia, Ms. Barnes was a health care consultant, policy analyst, health care attorney, and Capitol Hill staffer. From 2010-2012, Ms. Barnes was the director of Health Policy at the Bipartisan Policy Center, where she managed several projects on health professional workforce, insurance exchanges, and health information technology, as well as a health care cost containment project. From 2008-2010, Ms. Barnes directed the New America Foundation's non-partisan economic studies on the impact of proposed health reforms. For many years, Ms. Barnes was a litigator and regulatory counsel to health industry clients. From 1993-1994, Ms. Barnes worked on Capitol Hill as a legislative assistant on health care issues during the national health reform debate. Ms. Barnes was the long-time chairperson of the American Health Lawyers Association Health Reform Educational Task Force, served as the editor-in-chief of a legal textbook on managed care, and is a frequent speaker on health reform. She received her law degree from American University's Washington College of Law and undergraduate degree from the University of Iowa.

Krista Drobac, Executive Director, Alliance for Connected Care
Krista serves as the Executive Director of the Alliance for Connected Care, a 501(c)(6) organization dedicated to ensuring that all patients are able to realize the benefits of connected care. She was previously the director of the Health Division at the National Governors Association's Center for Best Practices where she directed technical assistance for governors' health advisors in the areas of health IT, health insurance Exchanges, Medicaid, delivery system reform and public health programs. Prior to NGA, she was a Senior Advisor at the Center for Medicare & Medicaid Services (CMS) working in Medicaid and private insurance regulation. She also served as Deputy Director of the Illinois Department of Healthcare and Family Services where she worked on policy related to Medicaid and state employee health benefits programs. Krista spent five years on Capitol Hill where she was a health advisor in the U.S. Senate. Krista holds a BA from the University of Michigan and an MPP from the Harvard University Kennedy School of Government.

Add Section section 603. EXPANDING THE USE OF TELEHEALTH THROUGH THE WAIVER OF CERTAIN REQUIREMENTS.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), as amended by sections 3(b) and 4, is amended by adding at the end the following new paragraph:

"(7) AUTHORITY TO WAIVE REQUIREMENTS AND LIMITATIONS IF CERTAIN CONDITIONS MET.—

"(A) IN GENERAL.—In the case of telehealth services furnished on or after January 1, 2018, the Secretary may waive any restriction applicable to the coverage of telehealth services under this subsection described in subparagraph (B) with respect to certain providers, provider groups, sites of care, services, conditions, individuals receiving the services, or States, as determined by the Secretary, if each of the requirements described in subparagraph (C) is met with respect to the waiver.

"(B) RESTRICTIONS DESCRIBED.—For purposes of this paragraph, restrictions applicable to the coverage of telehealth services under this subsection shall include requirements relating to qualifications for an originating site under paragraph (4)(C)(ii), any geographic limitations under paragraph (4)(C)(i) (other than applicable ~~state law~~ **State law requirements, including State licensure** requirements), any limitation on the use of store-and-forward technologies described in paragraph (1), ~~or~~ any limitation on the type of health care provider who may furnish such services (other than the requirement that the provider is a Medicare-enrolled provider)**, or any limitation on specific codes designated as telehealth services that are covered under this title pursuant to this subsection (provided such codes are clinically appropriate to furnish remotely)**.

"(C) REQUIREMENTS FOR WAIVER.—The requirements described in this subparagraph are, with respect to the waiver of a restriction described in subparagraph (B), the following:

"(i) The Secretary determines that the waiver is expected to—

"(I) reduce spending under this title without reducing the quality of care; or

"(II) improve the quality of patient care without increasing spending.

"(ii) The Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such waiver would reduce (or would not result in any increase in) net program spending under this title.

"(iii) The Secretary determines that such waiver would not deny or limit the coverage or provision of benefits under this title for individuals.

"(D) PUBLIC COMMENT.—The Secretary shall establish a process by which stakeholders may (on at least an annual basis) submit requests for a waiver under this paragraph.".

Amend section 303: Increasing Convenience for Medicare Advantage Enrollees through Telehealth

Add: Remote Patient Monitoring to the title.

Add: "(8) CLARIFICATION REGARDING REMOTE PATIENT MONITORING SERVICES.—For purposes of this subsection and section 1854, remote patient monitoring services shall be treated as if they were benefits under the original Medicare fee-for-service program option so long as such treatment does not increase the bid amount attributable to such benefits from the amount it would otherwise be, as determined by the Secretary.