ConnectedHealth

Connected Health Initiative (CHI) Recommendations:
Opportunities for HHS to Realize Benefits of Connected Health Without Congressional Action

Scope/Program / Regulation	Current Status/Issue	What HHS Can Do	Waiver Authority (if applicable)
Systemic (throughout HHS)	HHS lacks a Secretary-level initiative to promote telehealth within Medicare and Medicaid programs	Create a new Secretary-level initiative to promote telehealth within Medicare and Medicaid programs, similar to what the Veterans Administration has done to make telehealth a priority.	N/A
Physician Fee Schedule – definition of "telehealth"	Centers for Medicare and Medicaid Services (CMS) uses a more than outdated (over 15-years-old) definition of "telehealth" which limits telehealth reimbursement for the use of connected technology to live voice/video calls only	HHS should update its definition of telehealth (42 C.F.R. § 410.78) to bring the PFS into the 21st century. CHI has recommended an inclusive and technology-neutral approach to this definition.	N/A (CMS has narrowed its definition of an "interactive telecommunications service" further than required by the Social Security Act's § 1834(m), and could change this definition at any time).

Scope/Program / Regulation	Current Status/Issue	What HHS Can Do	Waiver Authority (if applicable)
Center for Medicare & Medicaid Innovation's (CMMI) Grants	CMMI has not adequately funded grants to explore the benefits of remote monitoring.	Adequately explore, track, and release data in a timely fashion from the Center for Medicare & Medicaid Innovation's (CMMI) innovation grants regarding telehealth and remote monitoring utilization.	42 U.S.C. § 1315a(d)(1)
CMMI Innovation Models; Medicare Alternative Payment Models (APMs) (e.g., Shared Savings Program)	Innovation models preclude the use of asynchronous/store-and-forward connected health tools.	Exercise statutory authority to waive payment and program requirements as appropriate to allow for remote monitoring to be used, including payment bundles and medical home demonstrations, and help providers utilizing APMs meet statutory requirements to reduce total costs.	42 U.S.C. § 1315a(d)(1) (in the case of CMMI Models) (e.g., as done with Care for Joint Replacement payment model); 42 U.S.C. § 1395jjj(f) (in the case of MSSP)
Accountable Care Organizations (ACOs)	ACOs are unreasonably limited from leveraging remote monitoring and telehealth innovations.	Allow ACOs to pay for remote monitoring and home-based video conferencing services in connection with the provision of home health services (under conditions for which payment for such services would not be made under the Social Security Act's § 1895 for such services) when such payments are not more expensive than furnishing a home health visit.	42 U.S.C. § 1315a(d)(1)

Scope/Program / Regulation	Current Status/Issue	What HHS Can Do	Waiver Authority (if applicable)
Medicate Diabetes Prevention Program (MDPP) model test	The MDPP does not leverage connected health technology's ability to improve program effectiveness while lowering program costs.	Expand the duration and scope of the MDPP model under the Social Security Act's § 1115A(c) as a timely and needed step to address the diabetes crisis in the United States. As CMS acknowledges, the use of connected health tech products and services will be vital to the success of the MDPP.	N/A
Physician Fee Schedule	Physician Fee Schedule does not provide adequate payment for online medical evaluations.	Establish positive Relative Value Units (RVUs) for online medical evaluations, including Current Procedural Terminology (CPT) codes 98969 and 99444.	N/A
Physician Fee Schedule	Telehealth critical care and evaluation are not supported by Physician Fee Schedule.	Add CPT codes 99291-99292 for critical care and evaluation.	N/A
Physician Fee Schedule	Physician Fee Schedule does not permit telehealth to be an option for the provision of regularly scheduled follow-up visits.	Allow telehealth to be an option for the provision of regularly scheduled follow-up visits.	N/A

Scope/Program / Regulation	Current Status/Issue	What HHS Can Do	Waiver Authority (if applicable)
Medicare and CHIP Reauthorization Act (MACRA)-driven Merit-Based Incentive Payment System (MIPS) Clinical Practice Improvement Activities	MIPS Clinical Practice Improvement Activities table does not adequately incorporate telehealth and remote monitoring for care coordination.	In MACRA, Congress specified that "telehealth and remote monitoring" shall be available to ensure care coordination within the MIPS Clinical Practice Improvement Activities (IAs), yet the IA final table fails to meet this congressional requirement as it describes two use case-specific examples, and does not provide an indication that telehealth and remote monitoring may be used widely to facilitate care coordination. CMS should provide an IA table that adequately reflects the role of both telehealth and remote monitoring in the IAs by providing use cases as well as context to explain that the use of telehealth and remote monitoring for care coordination within IAs is not limited to the unique condition-specific circumstances of the use cases provided. Similarly, it is essential that CMS clearly describe its obligations under MACRA and provide a robust rationale on its policy decision that fully and accurately portrays the congressionally-established role and scope of telehealth and remote monitoring in IA care coordination as well as in meeting IA requirements generally.	N/A
MACRA-driven Advancing Care Information Program (and Meaningful Use program)	Advancing Care Information Program is overly reliant on the nexus between CMS program participation and the use of certified electronic record technology.	CMS should reduce the reliance and tie between CMS program participation and the use of certified electronic health record technology (CEHRT). Excessive regulation and overly-prescriptive federal requirements have had massive unintended consequences, and physicians are now bound to use poorly-functioning CEHRT products—built primarily to measure and report on CMS requirements—and are disincentivized from adopting truly useful technology. CMS should identify methods to reduce the overreliance on CEHRT in its programs and allow for physician and patient choice to drive the adoption and use of health IT products.	N/A

Scope/Program / Regulation	Current Status/Issue	What HHS Can Do	Waiver Authority (if applicable)
Medicare Advantage	Medicare Advantage health plans are unable to elect to use telehealth and remote monitoring services as a basic benefit of service.	CMS should permit Medicare Part C, Advantage (MA) health plans to elect to use telehealth and RM services as a basic benefit of service. CMS can do this by providing a menu of remote monitoring or consumer oriented information technology categories that primary care and specialties would use for care improvement.	N/A
MACRA-driven APMs	CMS completely omits discussion of the role of connected health technology (telehealth and remote monitoring) in its final MACRA rule.	Revise the MACRA APM rules to explain the role of connected health technologies, how they will be leveraged, etc. A complete omission of this discussion from the rule is a disservice to the American public.	N/A
Food and Drug Administration (FDA) regulation of hearing aids/personal sound amplification products (PSAPs)	Regulations on hearing aids and restrictions on personal sound amplification products do not reflect current technological advancements, and disenfranchise countless Americans with hearing loss.	Place current Class I basic hearing aids under the agency's enforcement discretion, while down-classifying current Class II wireless air-conduction hearing aids to Class I while exempting them from good manufacturing practices.	N/A
Medicaid	HHS does not adequately encourage innovation in state Medicaid use of telehealth and remote monitoring.	Use Medicaid waiver authority to accomplish an initiative encouraging states to ask for waivers to include dual eligibles in their telehealth programs, and establish programs for dual eligibles such as Diabetes Prevention Programs, as age appropriate.	Social Security Act's § 1115; § 1915(b); and § 1915(c)

Scope/Program / Regulation	Current Status/Issue	What HHS Can Do	Waiver Authority (if applicable)
Anti-Kickback Laws	Lack of clarify from the Office of the Inspector General (OIG) regarding anti-kickback laws' applicability to providing care using connected health technology.	The Office of the Inspector General should provide clarification on what constitutes a violation of the anti-kickback laws (Social Security Act's §§ 1128A(a)(5); 1128(b)(7); 1128A(a)(7); and 1128B(b)) and the steps that can be taken to ensure that giving patients a device (e.g., an iPad) to communicate with a care team is not considered patient inducement; or use of a physician platform for treatment does not violate the anti-kickback statute.	N/A