CMS-1711-PRIN 0938-AT68. Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements (“Proposed Rule”)

Dear Administrator Verma:

On behalf of Philips HealthCare (Philips), I am pleased to have the opportunity to respond to the above 2020 Home Health Agency Proposed Rule (the “Proposed Rule”). Philips provides solutions that span the health continuum, including sleep management and respiratory solutions, imaging, patient monitoring, cardiac care systems; medical alert systems; healthcare informatics solutions and services; and a complete range of comprehensive telehealth programs. Of greatest relevance here, Philips provides a wide range of remote monitoring products and services for patients in all health care settings, including Intensive Care Unit (ICU), and other acute care and ambulatory settings. Our comments here focus primarily on the need to advance interoperability in post-acute care (PAC) settings and the potential impact of the Proposed Rule on remote patient monitoring of Medicare patients in these settings.

**Remote Patient Monitoring**

Philips strongly supported the 2019 HHA Final Rule, which authorized the inclusion of the costs of remote monitoring to be included in HHA cost reports for the purpose of determining base rates beginning in 2020. We note that this change is being implemented at a time when physician practices also are beginning to use the new remote patient monitoring CPT codes 99453, 99454 and 99457, which became effective and payable by the Medicare Program in 2019. The confluence of these changes has resulted in some confusion among physicians and home health agencies (HHAs) that we request CMS to clarify.

First, we request that CMS clarify that ordering physicians may bill for care management and remote monitoring codes if a Medicare patient also receives home health services, and that physician reporting of remote monitoring and remote management codes for patients who also receive home care services is not limited to circumstances under which the patient receives home infusion. In the Proposed Rule, CMS notes that:

…the ordering physician can bill separately for physicians’ services such as Chronic Care Management (CCM) and Remote Patient Monitoring codes under the PFS for care planning and coordination of home infusion therapy services.

This statement has resulted in some confusion regarding whether the remote monitoring/remote management codes can be billed by a physician for a patient who is receiving home health (but not home infusion) services.

*Recommendation: We urge CMS to confirm that a physician may bill for remote monitoring and for remote management services provided to a patient who is also receiving home health services.*

Second, because certain set up, education and other services can be provided either by HHAs or by physician practices, we believe that it may be useful for CMS to distinguish the circumstances under which set-up, education, and related services should be billed by physician practices from those under which the costs of set-up, education and related services should be included in HHA cost reports.

*Recommendation: Philips recommends that CMS clarify the services that can be included in a home health agency cost report, and crosswalk these services to corresponding CPT remote monitoring codes (i.e. provide a list of CPT codes matched to the use of remote patient monitoring by home health agencies reportable through cost reports and by ordering physicians billable through the physician fee schedule.)*

Finally a patient may require remote patient monitoring for more than one clinical condition. For example, a congestive heart failure patient may require remote patient monitoring that includes equipment such as a scale and tablet, and also may require remote monitoring of medication adherence that may be performed by a HHA.

*Recommendation: Philips recommends that CMS clarify that more than one kind of remote monitoring may be separately billable and covered, so long as all remote monitoring services are medically necessary.*

**Incentivizing Interoperability by Encouraging Remote Patient Monitoring**

The Proposed Rule includes a Request for Information (RFI) related to the need for interoperability in PAC settings through the published list of future quality measures, measure concepts and standardized patient data assessments (SPADES) in Table 27. We believe post-acute care is a vital aspect of population health management, readmissions reduction and healthcare system sustainability, and this area would benefit from expanded interoperable health IT. For this reason, Philips supports CMS’ goal of accelerating the adoption of interoperable health IT functionality in PAC settings, and believe that increased requirements that hospitals provide ADT notifications as a condition of participation (as proposed earlier this year) has the potential to make a significant difference.

We note that basic EHR adoption among HHAs and skilled nursing facilities (SNFs) is positive at 78% and 66% respectively, but that data exchange usage is relatively low. We believe that, in order to advance interoperability in these settings, it is important to adopt a clinically relevant and use-case driven focus that reflects the clinical needs of patients in PAC settings. In this respect, we urge CMS to consider accelerating the adoption of interoperable health IT functionality by providing financial incentives for HHA adoption of remote monitoring technologies.

*Recommendation: We are pleased that CMS has recognized the costs of remote patient monitoring in HHA cost reporting methodology and encourage the agency to accelerate the adoption of a mechanism for HHAs to obtain separate payment for remote monitoring services. Adoption of a mechanism for HHAs to obtain direct payment for remote patient monitoring would, we believe, spur adoption of RPM technology and care, thereby advancing the need for HHAs to exchange actionable patient data with acute and ambulatory systems and creating of shareable longitudinal patient records and other interoperability functions*.

*Recommendation: In light of the need to accelerate interoperability in the PAC setting, Philips support the inclusion of the exchange of EHI in the standardized patient assessment data elements (SPADEs) as well as the adoption of two interoperability-related process measures in the HHA Quality Reporting Program (QRP): Transfer of Health Information to Provider-Post-Acute Care and Transfer of Health Information to Patient (Post-Acute Care). Both measures speak to the care coordination and population health management inherent in discharge summaries already utilized within Medicare and Medicaid participants. Additionally, the second of these measures aligns with the patient-centric processes CMS has been emphasizing in recent rules. While we believe that exchange of medication lists is critical to high quality patient care in the PAC setting, we recommend that requirements related to exchange of this information be deferred, until the industry has more fully adopted the IT infrastructure that it has taken other sectors of the health care industry many years to develop.*

We appreciate the opportunity to comment on these issues. If you have any questions about these comments, please do not hesitate to contact me at [Lucy.McDonough@Philips.com](mailto:Lucy.McDonough@Philips.com).

Sincerely yours,



Lucy McDonough

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