



Submitted Electronically to: www.regulations.gov

September 21, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
P.O. Box 8016
Baltimore, MD 21244-8016.

Re: Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy (CMS-1734-P)

To Whom It May Concern:

The American Association for Homecare (AAHomecare) is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS') above captioned proposed rule. AAHomecare is the national association representing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members are proud to be part of the continuum of care that assures Medicare beneficiaries receive cost effective, safe and reliable home care products and services. As such, our comments are primarily focused on the telehealth and remote physiological monitoring (RPM) as it pertains to DMEPOS. While we understand that Congress must make some statutory changes in order for CMS to permanently authorize providers to engage in expanded telehealth activity, we want to take this opportunity to voice our support and explain how telehealth and other virtual services can be an efficient and effective way for physicians and beneficiaries to communicate about ongoing needs for DMEPOS.

Telehealth

Telehealth is an efficient way for practitioners and beneficiaries to communicate and can often effectively replace in-person visits, with no concomitant disadvantages. We strongly support the ability of beneficiaries and prescribers to conduct virtual services (e.g., telehealth, e-visits, and virtual check-ins),

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both during the PHE and beyond, in lieu of certain in-office visits. Virtual services allow the beneficiary and prescriber to appropriately communicate about ongoing needs, and in many situations, eliminate the need for an in-person (face-to-face encounter) visit to the doctor's office. AAHomecare strongly supports CMS' current expansion of telehealth services during this COVID-19 pandemic to facilitate access to care while minimizing in-person encounters. During the PHE this promotes social distancing, keeping both the beneficiary and health care practitioner safe. Expansion of telehealth has greatly improved the access to care without compromising the quality of services.

In the DMEPOS realm, there are many areas where the beneficiary is required to re-visit the prescriber to ensure continuing medical need and to obtain a prescription for refills of supplies. The purpose of these visits is to have the prescriber check-in with the patient to ensure she/he is using the equipment/supplies properly and to determine if the equipment and/or supplies are still medically needed. We believe this type of visit can be effectively conducted via a virtual visit. We believe the purpose of these types of in-person office visits can be more efficiently accomplished via virtual services and urge CMS to allow for these after the PHE has ended.

We strongly recommend virtual services that have been covered during the PHE be allowed on a permanent basis after the PHE. We recommend, however, that virtual services be reserved for physicians and other prescribers with an established beneficiary relationship. Virtual services can effectively be used in situations where the prescriber has an ongoing relationship with the beneficiary, has already prescribed the medically necessary DMEPOS item, and simply needs to check-in with the beneficiary to ensure continued medical need, or recommend a change in the supplies ordered.

Another benefit of telehealth we have seen during this pandemic is that it has provided an opportunity for patients to seek medical care before needing to visit a facility. The Centers for Disease Control and Prevention (CDC) has reported that emergency department visits dropped by 42% between January 1-May 1, 2020, due to the pandemic.¹ Although this steep drop is disconcerting, the expansion of telehealth during this PHE is likely limiting some emergency room visits. Telehealth expands access to care by allowing patients to get medical attention without leaving their homes, this is especially important for high-risk patients who should limit leaving their homes during a pandemic.

Prior to the PHE, telehealth was limited to Medicare beneficiaries residing in rural areas. Although the availability of telehealth has been very helpful for rural communities, the difficulty accessing a clinician's office is not limited to these areas. For a variety of reasons, even beneficiaries residing in urban areas can struggle to visit a doctor's office. Whether it be due to a transportation issue, a medical condition (such as limited mobility), or the flu season/pandemic (where the patient is fragile), there are situations when telehealth is safer than an in-person visit. The geographic barrier to virtual visits should be removed. CMS should implement rational, practical rules with input from all provider communities to expand access to telehealth responsibly to protect the Medicare Trust Fund. Removing the geographic barrier and expanding eligible services during this pandemic has revealed that telehealth is an effective alternative to in-person visits.

Remote Physiologic Monitoring (RPM) Services

AAHomecare supports the expansion of remote physiologic monitoring (RPM) services to further enable access and quality of care for beneficiaries. Digitally enabled medical devices, including certain DME items, help collapse time and space by capturing snapshots of physiologic data. The exciting area of digital health

¹ Centers for Disease Control and Prevention, Impact of the COVID-19 Pandemic on Emergency Department Visits — United States, January 1, 2019–May 30, 2020. Published June 12, 2020: <https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm>

allows multifaceted capture, documentation, and reporting of precise health conditions, triggering events, dates, times, and other contextual data. Some devices not only monitor the patient's disease status but also deliver medicine or therapeutic care. Using digitally enabled medical devices and their associated services, medical practitioners and payors can monitor patient conditions, while documenting use, functions, trends, conditions, environmental status, location, and other aspects of patient compliance, care, and necessities. Prescribers and other qualified health care professionals can utilize home use medical devices to gather information associated with diagnosing, treating, or managing a clinical condition. Unlike before when this information was only captured episodically in between medical visits, the availability of this new information can help improve care management, leading to better patient outcomes, and potentially resulting in increased cost savings.

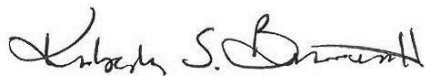
For the purpose of gathering information related to diagnosing, treating, and managing a clinical condition for which DMEPOS is ordered, AAHomecare recommends CMS allow RPM to satisfy the requirement for the face-to-face encounter. RPM services enable physicians and other qualified health care professionals to gather information and monitor patient treatment.

AAHomecare recommends CMS adopt policies that would improve the partnership between the DMEPOS industry and physician community in caring for patients. DMEPOS suppliers are more frequently in contact with beneficiaries after a doctor's visit and are in a suitable position to monitor and communicate between patients, physicians, and referral sources. In addition, some DMEPOS suppliers already provide equipment that has monitoring technology which has improved supervising patient health in real time. RPM can be used in tandem with expanded virtual services to provide a robust patient-centered visit without the need for an in-person visit.

The DMEPOS industry is conscious of bad actors targeting elderly and disabled individuals and the potential risk of fraud and abuse with the expansion of telehealth. AAHomecare and other leaders within the DMEPOS industry have been proactive in educating suppliers to not engage in questionable telehealth arrangements and encourage self-policing if there are any suspicious activity. AAHomecare strongly recommends that CMS protect beneficiaries and the Medicare Trust Fund as telehealth is expanded. We believe telehealth services can be responsibly extended, improving patient care without compromising program integrity.

We appreciate the opportunity to provide comments on this proposed rule. Please feel free to reach out with any questions, or if you would like additional information.

Sincerely,



Kimberley S. Brummett
VP, Regulatory Affairs
American Association for Homecare