February 10, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013 Baltimore, MD 21244–1850

Re: Changes to Medicare telehealth services
Submitted via email to CMS Telehealth_Review_Process@cms.hhs.gov

The Digital Medicine Society (DiMe) appreciates the opportunity to provide input in response to the request for comments to future telehealth coverage and payment policy made by the Centers for Medicare & Medicaid Services. The input in this document pertains to the opportunity of an emerging care model, digitally-enabled virtual first care (V1C), to drive high value, equitable, and affordable healthcare in the US, deploying the tools of digital medicine, including telehealth, to redefine the healthcare value chain around access, efficiency, effectiveness and equity.

DiMe is a global non-profit that partners with experts from across the technology, health care, and public sectors to conduct field-leading research and develop **pre-competitive resources that accelerate the ethical, effective, equitable, and safe use of digital medicine to redefine healthcare and improve lives**. DiMe's portfolio spans efforts in digital measures, regulatory science, and healthcare and public health, including an initiative called 'IMPACT', aimed at expanding access to high quality, evidence-based V1C for patients, healthcare providers, and payers to improve clinical and health economic outcomes, enhance access, and provide a better overall patient experience. Through the IMPACT initiative, DiMe has identified the unique capacity of V1C to drive healthcare redesign that is truly patient-centered, outcomes-focused and sustainable: **This is the focus of the input provided in our response.**

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Benefits and Limitations of Current Telehealth Coverage and Payment

We applaud CMS for supporting the use of synchronous video and telephonic telehealth throughout the pandemic and for the near term. There is no question that the pandemic and PHE flexibilities for telehealth coverage have accelerated the use and acceptance of synchronous virtual visits as a substitute or complement for in-person care. The past few years have afforded a natural experiment that has produced convincing evidence that telemedicine can expand access to acute and chronic care for previously underserved populations without duplicating services or jeopardizing clinical quality. Payment parity has been beneficial to V1C companies and provides necessary support for the infrastructure, as well as provider services, needed to deliver virtual care, amass evidence and begin the process of learning what it will take to ensure telehealth is equitably available to people of all socioeconomic, racial/ethnic groups, and diverse needs.

However, coverage and payment for live virtual visits that simply replicate our existing care model in the digital environment don't go far enough to address the crippling inefficiencies and inequities, shrinking provider access, soaring costs and lackluster clinical outcomes in our healthcare system.

The current telehealth payment system remains **highly limited as relates to how we effectively integrate digitally-enabled telehealth into a redefined value chain** characterized by a virtual first, hybrid healthcare delivery model.

Specifically, the following gaps in current CMS coverage are attenuating the delivery of equitable, high quality, virtual first hybrid healthcare:

- **No coverage paths for on-demand, asynchronous**, digitally enabled interactions between clinicians and patients despite the evidence that these modalities have been proven to expand access for underrepresented populations, improve engagement, and expand access to evidence-based primary care, mental illness and behavioral health care, and enable successful integration of specialty care programs,such as weight-loss programs, into population health initiatives.
- **Paucity of coverage for team-based care**
    - No coverage for evidence based, coach-driven behavior change programs in the virtual environment, e.g., for diabetes prevention and management, mental and behavioral health. This gap limits access and choice for patients who are most likely to suffer from these chronic conditions - those in Medicare and Medicaid populations.
    - Limited ability to obtain reimbursement for care navigation and coordination, 'wrap-around' services that are critical to seamless longitudinal care for chronic conditions
- Existing payment codes for virtual management and secondary preventive care of diabetes and hypertension often require **patient cost-sharing that disincentivizes patient participation**.

- **Insufficient payment rates for virtual services to support health practice investments** in technology and data infrastructure, staff training, and continued research and development using innovative digital platforms and analytics that improve efficiency and user experience for patients, caregivers, and providers.

Without fundamental care redesign our system will be challenged to meet the mounting demands of chronic illness and accelerating mental and behavioral health needs amidst provider shortages and facility capacity constraints. We've reached the point where wait times for primary and specialty care are becoming a safety and quality issue - Virtual-first care is not 'just' about convenience for middle-class urban dwellers. **Virtual-first care is proving to be a powerful approach for ameliorating these challenges in the commercially insured and self-pay markets.** We respectfully request that CMS work with stakeholders such as DiMe to design a payment structure that supports evidence-based V1C.

Redefining the Healthcare Value Chain Through Virtual First Hybrid Care

V1C is defined by the IMPACT Initiative as medical care for individuals or a community accessed through digital interactions where possible, guided by clinicians, and integrated into a person's everyday life. V1C decouples the provision of care from the traditional cadence of office visits and bricks and mortar through application of digital tools, including omnichannel communications, remote monitoring, and AI-powered decision analytics to support multidisciplinary care teams over a complete care journey. V1C has the potential to break the 'iron triangle' of cost-quality-access by remodeling the delivery process of health care along a value chain that is aligned with patients' lived experience of their condition, prioritizing activities and interventions that are most productive in terms of producing meaningful clinical outcomes.

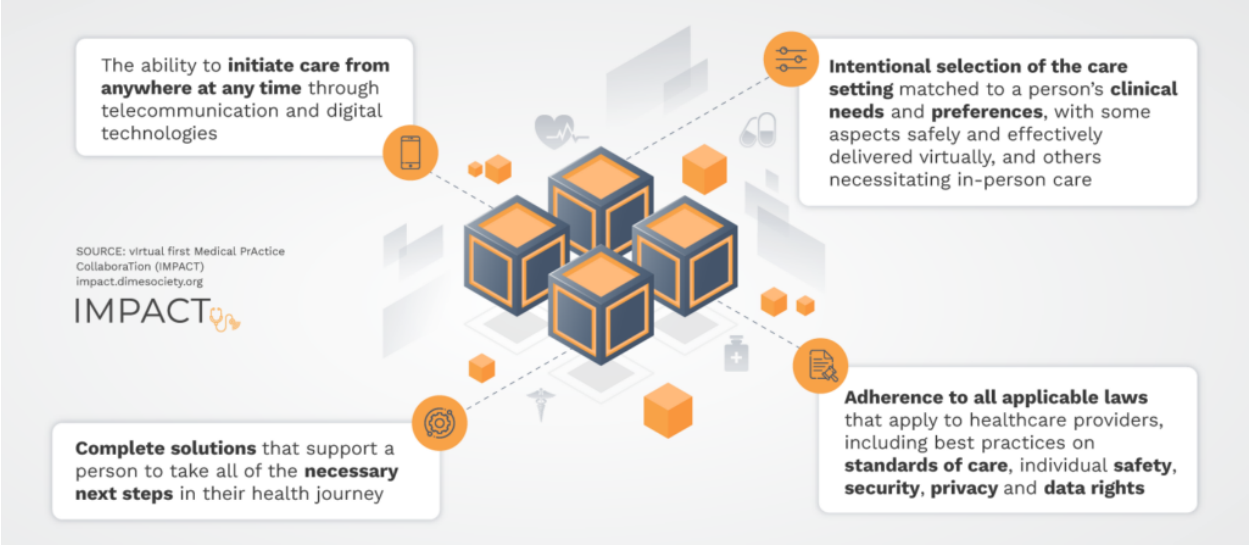
In this model, **workflows are optimized for patient outcomes, rather than encounter volumes and billing**. This shift enables intentional selection of sites of care both in-person and virtual, and digital communication modes that mitigate barriers of time and place that stand between patients and providers in the traditional model of care. The result is that a patient living with a chronic condition such as heart failure or COPD has as-needed access to a complete care solution including medical care and supportive services such as nutrition, mental healthcare and skills building coaching for improved self-management. When done well, virtual first care can provide the care a patient needs where they need it, when they need it, and from whom they need it.

V1C is characterized by:

- The ability to **initiate care from anywhere** at any time through telecommunication and digital technologies

- **Intentional selection of the care setting** matched to a person's clinical needs and preferences, with some aspects safely and effectively delivered virtually, and others necessitating in-person care
- **Complete solutions** that support a person to take all of the necessary steps in their health journey
- **Adherence to all laws** that apply to healthcare providers, including best practices on standards of care, individual safety, security, privacy and data rights.

Exhibit 1. Characteristics of the V1C Healthcare Delivery Model



V1C is evidence-based healthcare that is critical to the hybrid care model that is our future. A strong trend of demand and uptake in the privately insured market shows that a subset of our population are starting to benefit from V1C. A national benchmarking survey of >800 payers, employers and benefits consultants revealed **well over half of all benefits decision-makers** indicate:

- "Virtual care is an extremely/very high priority"
- "Virtual care is a principal means of improving patient care and outcomes"
- "Virtual care is a real opportunity to transform healthcare in ways that positively address social determinants of health (SDOH)"
- "Virtual care is here for the long term (regardless of COVID)"

Importantly, the survey revealed that top priorities for virtual healthcare offerings are strongly aligned with principles of V1C, including patient engagement, access to data and information, personalized care solutions, and streamlined connections across providers. We believe it is necessary to take immediate steps to **extend these benefits to CMS beneficiaries** who are likely to reap the same benefits of V1C as the rest of the population. Emerging evidence from the pandemic shows that the Medicare population is eager to use telehealth, with more than 40 percent of Medicare beneficiaries used telehealth during the first year of the pandemic, and **V1C platforms can be effectively tailored to seniors**. Thus, effective coverage and payment for V1C are essential to

healthcare equity for the Medicare population. In this comment we recommend steps that CMS can take to ensure that our nation benefits from the full potential of digitally-enabled hybrid and virtual healthcare.

Priorities for Coverage and Payment of V1C

Despite growing evidence, as well as momentum and uptake of V1C from employers and health plans, and broad acceptance by consumers, it is currently very difficult for providers to get paid for these services in the virtual setting. The tremendous administrative frictions involved to set up these models currently in the private sector **drive up costs and limit access to patients who can pay directly**, or who have innovative employer-based health plans. Coverage and payment in the future must:

- Smooth the way for synchronous and asynchronous interactions between clinical teams and patients
- Encourage the use of biometric and other sensor technologies to share real-time data across all members of the care team
- Embrace personalizing approaches to optimize every patient's care journey
- Incentivize hybrid interdisciplinary approaches that include specialists to provide comprehensive and long-term care.

Leadership from CMS in creating payment pathways for V1C will not only bring access to high value care to CMS beneficiaries, but provide a payment roadmap that facilitates delivery system transformation in the commercial and employer-based markets. Addressing the following priorities will allow both new and incumbent providers to achieve success in the redefined value chain.

Priority #1 Create coverage pathways for digital and virtual care channels beyond video visits

Reflecting on the case studies presented at the January 26th workshop, ***why do asynchronous and chat-based care V1C programs achieve such compelling health and economic outcomes*?** They don't utilize more specialty physician touchpoints, procedures, or prescription medications, nor do they leverage innovative care protocols. **What V1C does uniquely well is honor and value individuals' time and efforts to be active participants in their care.** Digital tools, applied in a V1C delivery model, enable a vastly improved experience for patients and providers by meeting patients where they are: geographically, culturally, and personally, and supporting achievement of **goals that are meaningful for patients and providers.**

While we support CMS actions to make permanent the PHE-era flexibilities that allow for coverage for video and audio-based telehealth services as a means to ensuring continuity of access to this proven modality, synchronous visits are only one tool for change. Transformation of our healthcare system towards a sustainable, high value, and equitable future depends on building *continuous connections* between patients and their care and care teams, and **coverage that is agnostic of the modality of interaction** but strongly

aligned to the value of health outcomes created. The future of our hybrid healthcare system depends less on the specific modality used to deliver care, and more about giving people the flexibility to choose when and whether to receive in-person or virtual care, on what platform, and when clinically appropriate in order to optimize outcomes and access. It is imperative that CMS create a plan to provide coverage for the breadth of proven digital engagement and care tools that V1C now routinely relies upon, including: video, audio, phone, remote patient monitoring, text-based chat functionality and other asynchronous interactions such as email, and especially app-based patient self-management, skills-building and education.

Priority #2 Redesign payment models for hybrid system of cares for chronic disease

There is a widely acknowledged disconnect between the guideline-driven, collaborative, interdisciplinary model of care that we know works for individuals with one or more chronic conditions and our current healthcare value chain which is anchored on incentives for infrequent doctors visits and procedure-based reimbursement. With data-driven digital medicine we now have powerful tools to redesign healthcare delivery, considering **each component of the value chain,** particularly prevention and screening but also triage, diagnosis, treatment, referrals to tertiary/quaternary care, and long-term management. As alluded to in the case studies below, this new value chain must include **engaged patients as key players**, **intentional selection of sites of care**, both virtual and in-person, and **heavily weigh care models and practices that promote outcome-linked, sustained engagement**.

Exhibit 2: Characteristics of a value-chain approach to redesigning healthcare using digital technologies

Characteristic	Value Drivers			
	Access	Efficiency	Effectiveness	Equity
Hybrid approaches that optimize in-person, synchronous, and asynchronous modalities	x	x	x	x
Build engagement, trust, and confidence	x		x	x
Invest in most productive interventions – primary and secondary prevention		x	x	
Accelerate quality improvement by leading with equity, build consistent application of knowledge		x	x	x
Enhance professionalism by supporting total health workforce, ethics	x		x	x
Simplify engagement for patients and providers by using platforms that integrate point solutions and advance user experience	x	x	x	x

There is plenty to learn from the **Veteren's Healthcare Administration (VHA) approach to evaluating and implementing digitally-enabled innovation.** For example, taking a value chain approach, when considering future investments for Medicare beneficiaries, CMS should **focus on the most productive interventions**, those which will have the most impact on primary and secondary prevention. In the case of chronic condition management, the most productive interventions are those which include support for sustained patient engagement. In highly prevalent chronic conditions such as depression and anxiety, sleep disturbance, diabetes, hypertension, and heart failure, COPD, and others there is mounting evidence that as part of a comprehensive clinician led program,

supplemental management by **trained behavioral health coaches** is an instrumental component of care achieving outcomes over and above those available with evaluation and management (E&M) alone. Regardless of how they are delivered (in-person, telehealth, app-based) holistic care models that incorporate dietary and behavioral changes and skills building are a critical factor in achieving outcomes and should be covered services reimbursed at rates commensurate with that value.

Likewise, when designing payment for a digitally-enabled hybrid era of healthcare, we recommend CMS **build on existing models of paying for holistic, team-based care models** such as the Collaborative Care Model and Patient-Centered Medical Home models. By incorporating digital technology and V1C delivery principles it will be possible to extend models such as these to additional chronic conditions and radically scale sustainable virtual-hybrid programs despite shrinking healthcare workforce and increasing demand.

Finally, successful implementations in the commercial market that **blend risk-adjusted prospective payment with outcomes focused milestone and engagement payment** have laid the groundwork for how CMS can shift towards value-based care in the digital era. Future CMS payment pilots must explore how to redesign the value chain around episodes of care based on patient-salient outcomes measures rather than clinician activities. Payment pilots should also define how CMS can use innovative digital technology and virtual care modalities to design more sophisticated ways of determining and managing risk such as:

- Patient self reporting
- Clinical assessment
- Digital analytics to assess risk
- Activity & patient engagement with healthcare platforms

Priority #3 Align Compensation Along a V1C-Enabled Hybrid Care Value Stream to Incentivize Continued investment in Innovation

V1C can play a role in both decreasing costs and improving outcomes for patients but only if incentives are aligned and appropriately valued to reward models that work. There has been much discussion about how to compensate physicians for telemedicine, considering factoring in variables of time, medical decision-making, malpractice expenses, and practice expense. This work is valid and necessary to align compensation for physicians who perform synchronous video and telephonic visits within an otherwise conventional care delivery model. However, as we've demonstrated in previous sections, telemedicine visits alone will not enable the fundamental redesign of the healthcare value chain. The digital era of healthcare demands new approaches to **a) understanding the costs of the 'inputs' as well as correctly assigning value to the outcomes created.**

While V1C providers do not have capital investments in facilities and equipment, they have significant operating costs over and above clinical and administrative staff. Many V1C practices invest heavily in technology - robust data infrastructure is essential for creating

a compliant, secure, and seamless digital patient experience for providers and patients. Additional 'technology stack' investments often include interoperability engines, software applications to enable data-driven clinical decision-making, and automated monitoring and use of real-time data from connected devices to appropriately triage patient needs to the right provider on an interdisciplinary team. For example, a V1C provider that focuses on cardiac health reviews data that is continuously collected from patients through remote monitoring devices, app-based messaging, virtual provider visits, and even remotely conducted cardiac ultrasound devices. Integrating these data inputs in real time through sophisticated algorithms enables the clinical team to accurately titrate medications and act to prevent exacerbations that would otherwise lead to costly emergency care and inpatient hospitalizations. In this case, paying only for the time spent during an e-visit or the remote monitoring fails to account for the value of upstream secondary prevention made possible by complex data science at work alongside clinicians.

CMS can play a key important role in defining how our nation values V1C going forward. Future payment pilots must **study the costs and outcomes of V1C delivery models in real world settings** and in comparison to traditional care. To do this we need to be able to **track the 'inputs' of new compare models at a sufficiently granular level**. This will require collaboration with industry and professional associations to devise and implement coding strategies that reflect all the types of care that go into a comprehensive V1C model, and measures of value that reflect sustainable and meaningful patient outcomes.

Learning from Successful V1C Implementations

Virtual first care has been remarkably effective as implemented by innovative public and private sector leaders. On January 26, 2023, DiMe convened a **multi-stakeholder workshop with over 50 executive leaders from across healthcare, including healthcare systems, health plans, employers, technology companies and V1C provider entities** to develop recommendations for V1C-aligned payment policy. The following three scenarios and case studies illustrate how V1C can be successfully implemented in practice for diverse populations, and underscore the importance of re-aligning policy to expand access to these models of care to CMS beneficiaries.

1) V1C Behavior Change Programs

A wide variety of chronic conditions including anxiety and depression, cardiometabolic syndrome, chronic kidney disease, and post-acute recovery for COPD and cardiac events are amenable to lifestyle and behavioral changes complementary to and supportive of medical management, but it is well known that patients struggle to meet their goals in conventional healthcare settings due to a variety of barriers including comorbidities, transportation, childcare, employment and Incompatibility with personal lifestyle.

Case Study: Omada Digital Diabetes Prevention Program (dDPP)

Background: Omada Health provides a digital diabetes prevention program through employee health benefits plans, risk-bearing health systems and to eligible commercially insured patients as part of its suite of V1C chronic condition management services. Their program is recognized by the CDC as meeting the evidence-based standards for the agency's National Diabetes Prevention Program (DPP). The clinically-validated, 16-week program combines on-demand personal health coaching, peer support, and connected remote monitoring technology to help individuals make lifestyle changes that lead to weight loss associated with reduced risk of chronic disease. Patients engage with the program entirely through digital channels, access content and communicating with providers and coaches through a smartphone, tablet, or computer.

Evidence: Omada Health has amassed a significant body of evidence that demonstrates clinically significant, sustained reductions in HbA1c and body-weight compared to usual care, effectiveness in Medicare populations, and can be successfully adapted to serve patients in underserved, minority, and low income populations. The program also produces strong health economic outcomes, reducing all-cause health care costs (more than $1,000 per participant per year), with savings driven by reductions in hospital admissions.

Addressing Payment Frictions: Digital access to evidence based, protocol-driven behavioral change programs provides an alternative approach to diabetes prevention for populations that more often experience difficulty accessing in-person health services. However, despite evidence that coach-supported chronic care is highly effective in the Medicare population, current CMS policy does not allow for coverage of virtual care by coaches or any asynchronous care interactions by qualified health care providers. Organizations like Omada Health and the many established providers who deliver digital mental and behavioral health services through asynchronous, coach-driven programs rely on a complex patchwork of reimbursement built on per member fees, patient engagement metrics, and outcomes milestones in their commercial contracts. These contracts are cumbersome to implement absent codified structures from CMS, but they work effectively to match incentives to patient outcomes and continue to grow in the market.

2) On-Demand V1C Speciality Care

The growing shortage of medical providers, particularly specialists, is expected to continue to affect the United States population for years. It is already manifesting through long wait times. Additionally, the geographic distribution of specialists can make the problem even more pronounced for patients in rural or underserved areas. Even in major metropolitan areas wait times for specialists averages 26 days across the United States. Undoubtedly, lack of access to care translates to poorer health outcomes and/or more expensive care. For example, some studies have shown that when patients cannot see a provider, they turn to urgent care. To combat the shortage of medical providers we need to design care models that use credentialled clinicians more efficiently, and make them available to patients regardless of geographic location. Members of the IMPACT initiative have reported that on-demand care through asynchronous communication supported by a virtual care platform improves efficiency, reducing interaction time from

an average of 18 minutes to 3.6 minutes. When protocols and decision support analytics are built in, it also eliminates variability and increases the validity of the digital evaluation.

Case Study: Cove V1C Clinic for Migraine

Background: Over 39 million people in the US suffer from migraine. Most of these patients face barriers to appropriate care including geographic and socioeconomic limitations, a shortage and uneven distribution of certified headache specialists, and a lack of widespread awareness and adoption of current guidelines for migraine management. Thirty Madison provides care for patients with migraine headache via their Cove platform, a V1C clinic available directly to consumers through a membership model or through select commercial health plans. The Cove care model provides access to a comprehensive asynchronous consultation with headache specialists who receive training and oversight by leading board certified neurologists and experts in migraine care. Patients typically receive a diagnosis and personalized treatment plan within 48 hours. Any necessary treatments can be shipped to home directly via e-pharmacy services, and patients maintain ongoing access to an integrated care team for support and resources to manage their condition, including integrated cognitive behavioral therapy (CBT)-based behavioral health support and coaching tailored to migraine. On top of gains in patient access and practice efficiency reported by others using asynchronous care, Thirty Madison providers report that the text-based communication better enables their patients to relate the chronology of their symptoms, improving ability of physicians to personalize care, and the digital environment facilitates faster cycle times for fine tuning treatment plans compared to standard practice.

Evidence: Headache care in this digital environment has proven effective at improving access to evidence-based headache care, with average wait time <20h, a tremendous achievement considering that 46% of Cove's migraine patients live in a county without a single headache specialist. Patients in the Cove program experienced reduced number of headaches and reductions in headache pain on standardized scales. Importantly, it was recently demonstrated that this program provides access to underrepresented minority patients, over 80% of whom would otherwise not have access to primary care or specialists for their headache prior to joining the platform.

Addressing Payment Frictions: The application of on-demand specialty care with **supportive wrap-around care and integrated mental & behavioral health** is a common characteristic of V1C providers, so payment for these models was an important theme of the recent workshop. However, integrated on-demand virtual care, founded on a basis of asynchronous care interactions, is not currently covered by conventional payment codes. As a result, most V1C companies offer services directly to self-pay consumers, through employer benefit programs, and, with tremendous 'one-off' administrative efforts, through health plans. To democratize this model it is critical that CMS addresses the lack of coverage for digital care channels with demonstrated evidence of increased patient engagement, satisfaction, and access to evidence-based care. These channels, ubiquitous outside of healthcare, expand beyond real-time video visits to include text-based communication, email, and app-based interactions.

3) Hybrid V1C Care for Chronic Conditions

We appreciate the attention CMS has paid to the challenge of managing chronic conditions. These efforts clearly underscore that chronic disease cannot be fully and effectively managed in 15 minute increments within the walls of a clinic. Chronic care has to be embedded in people's lives to be effective and the constraints of our current workforce, physical clinic capacity, and visit-based payment models don't do that justice. As patients age, and develop more chronic diseases, their need for coordinated, team-based care will increase. It is imperative that the future payment system, led by CMS supports a redesigned delivery model for chronic care that incorporates frequent touchpoints –both synchronous and on-demand–, continuous monitoring, and sophisticated analytics that enable timely secondary prevention interventions.

Case study: Team-Based V1C Specialty Care for Chronic GI Disorders

Background: Chronic gastrointestinal disorders have a high morbidity and economic burden, affecting more than 70 million people in the USA, and driving more than $135 billion in annual healthcare costs due to unmanaged symptoms, avoidable emergency services, testing, and procedures. Patients with digestive health disorders suffer long wait times for in-person appointments and struggle to access dietary and behavioral therapies that are proven to improve and control symptoms.

Oshi Health provides care for gastrointestinal disorders via a virtual first clinic model which combines high-touch virtual multidisciplinary care from gastroenterologists, advanced practice providers, GI registered dietitians, GI-specialized psychologists, and health coaches. Patient care plans are personalized and continuously informed and refined by a data-driven approach to tracking validated patient-reported outcomes (PROs) and dietary monitoring; health coaches provide patient-tailored support with behavior change, goal setting, and care plan adherence. The virtual clinic coordinates with patients' in-person gastroenterologists and primary care clinics to ensure seamless care transitions throughout the patient journey. This care model adheres to protocols that are clinically validated and recommended by the American College of Gastroenterology and American Gastroenterology Association, but are rarely implemented in clinical practice due to reimbursement and access challenges.

Evidence: Results of a prospective clinical trial presented at the December 2022 Institute for Healthcare Improvement (IHI) Forum show that this V1C care platform resulted in significantly higher levels of patient engagement, satisfaction, and symptom control. Significantly, the trial also showed that patients had fewer missed work days, improvements in work productivity, and statistically significant reductions in healthcare costs after six months, compared to propensity-matched controls.

Addressing Payment Frictions: This care model combines the concepts of interdisciplinary, team-based specialty care, extensive wrap around services such as navigation and coordination, and on-demand asynchronous personalized coaching and dietary support. At present, outside of the synchronous E&M visits, it is not possible to obtain appropriate coverage and payment through existing CMS payment methodologies. In the workshop this was a common concern echoed by other providers with similar models that leverage data-driven decision making and team based care to provide

specialty care for chronic conditions. To extend this model to CMS beneficiaries will require a plan for reimbursement that captures the comprehensiveness of care delivered by the practice using existing payment codes or developing new payment approaches that strike a balance between care activity and achievement of outcomes.

These examples and numerous others presented at the January 26th workshop and within our IMPACT membership have highlighted evidence that V1C is a delivery model that can work very effectively to deliver efficient, evidence-based care. However, until we have federal policy supporting interdisciplinary team-based care and asynchronous interactions the benefits of team-based V1C for chronic conditions will be inaccessible to many patients, including CMS beneficiaries. The way forward involves designing coverage and appropriate payment for expanded digital care channels in the short term, and focused efforts by CMS to devise a path to marry V1C principles with innovative care and payment designs such as the collaborative care and medical home models which are built on a patient-centric value chain and promote the trend towards risk-sharing and outcomes-focused payment.

Conclusion

We are at a critical time in the development of V1C care, which provides CMS an opportunity to structure a payment system that rewards keeping people out of the hospital and away from the clinic, free to live the life they chose unencumbered by their medical conditions. The fundamental redesign required to implement virtual first care (V1C) – high-quality healthcare delivered virtually until it cannot be – will allow both new and incumbent providers to achieve success in the redefined value chain.

When CMS creates coverage pathways for digital and virtual care channels beyond video visits, it will remove barriers to synchronous and asynchronous interactions between clinical teams and patients, and fully leverage biometric and other sensor technologies to make real-time data available across all members of the care team. V1C practices use these data to personalize approaches to optimize every patient's care journey, and embrace an interdisciplinary approach that includes specialists to provide comprehensive and long-term care. Redesigned payment models for hybrid systems of chronic care will allow for a virtual-first approach and reshape our ability to provide care for people centered on their needs rather than the healthcare system – precision care for all people, in the digital era.

In order to realize the full potential of virtual care, CMS must consider the comprehensive value – beyond 'just' dollars and cents – that V1C approaches can deliver. Telemedicine is a visit focused on managing sickness, V1C is a journey pursuing health. But V1C can only extend fully into mainstream healthcare when CMS aligns compensation along a V1C-enabled hybrid care value stream and incentivizes continued investment in innovation

As part of our work at DiMe, we will continue to create, share and request pathways and best practices to further V1C as an evidence-based practice. We would value the opportunity to collaborate with CMS on the type of evidence needed for coverage. DiMe appreciates that CMS has undertaken the difficult work related to telehealth and telemedicine and we look forward to working with you on this important effort.

Sincerely,

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