March 26, 2020

The Honorable Alex Azar II
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Expanded Rulemaking to Fully Enable Telehealth to Protect Medicare Beneficiaries During the Coronavirus pandemic

Dear Secretary Azar and Administrator Verma:

The current environment with the coronavirus pandemic is emergent and a human tragedy. There are, however, opportunities out of every crisis to fundamentally build strength – both in immediate mitigation and stabilization as well as long-term sustainability. Given how important social distancing is – and will continue to be – we applaud the steps CMS has recently taken to expand telehealth services for traditional Medicare beneficiaries with the 1135 waiver, but we believe additional steps are needed.

Most urgent are:

1. **Telehealth eligibility for risk adjustment:** Allowing all forms of telehealth (including audio-only phone encounters) to be eligible for disease burden capture for risk adjustment in CMS programs (e.g., the identification and (re)confirmation of hierarchical condition codes (HCCs) within Medicare Advantage (MA) or Medicare Shared Savings Program (MSSP) during the period of the pandemic.
2. **Telehealth reimbursement:** Leveling the playing field for providers seeking telehealth reimbursement to be "made whole" when providing telehealth services rather than in-person care.

The signatories of this letter lead some of the most prominent primary care groups in the nation, and collectively provide services to well over two million MA and MSSP members. We all are

innovators, with some of the strongest track records of success in value-based care. Managing beneficiaries across geographies, programs, and relative complexity/acuity of patients, we have unparalleled insight into what providers must do holistically to deliver better outcomes at lower costs.

Our Position & Rationale

Like you are, are working tirelessly to protect Medicare beneficiaries from coronavirus. It is with special concern for those at the most risk – older Americans with multiple, complex medical conditions; many of whom have limited economic resources to stay safe – that we urge you to make meaningful expansions of telehealth rules. Our organizations care for many of these particularly vulnerable Medicare beneficiaries and we request that CMS immediately approve policies that allow us to stabilize, mitigate, and strengthen the programs that millions of Medicare beneficiaries rely on for their well-being.

Telehealth eligibility for risk adjustment:

We believe it is important that CMS immediately create appropriate rules for risk-bearing Medicare entities (e.g., Medicare Advantage Organizations (MAOs) and their contracted providers and MSSP participants) that **allow for all forms of remote patient engagement (where a licensed provider is present) to count as an encounter used in risk adjustment during the period of the pandemic.**

While a majority of Medicare beneficiaries currently exposed to the risk of coronavirus are in traditional Medicare arrangements, MA, MSSP and other risk programs still represent well over 30 million Americans – and growing. The need for MA and MSSP specific rules is critical.

Our top priority is to keep patients well. The requirement, therefore, is to engage the patient enough to build trust and be able to identify every risk they have to good health – both existing disease burden, as well as risk identification from lifestyle and social determinants. The pathway to do that extends far beyond office-based visits, especially during this pandemic. The current environment of social distancing and isolation resulting from governmental and clinical coronavirus recommendations evidences this. This is further complicated for many seniors who do not have internet access at home and are unable to access critical coronavirus information.

Telehealth has long been a brewing topic with appetite by policy makers and providers to leverage technology to improve care. But, to date, this has been narrowly construed as a certain type of visit – a synchronous 2-way video visit with pre-defined elements such as “originating” site and established patient-provider relationship.

The reality of many Medicare beneficiaries, and especially those with the highest risk of mortality from coronavirus, is that current rules block them out from eligible telehealth visits. A significant

subset of our patients reside in dense, non-rural areas. They do have "nearby" doctors, but don't have the access to (or comfort with) smart phones that have broadband Wi-Fi or high-speed cellular data connections. In fact, many of them have no internet connectivity at all. Or, if they do, they may not be able to afford the data usage of a high-quality video call. The beneficiaries most likely to be in this situation, are also the ones most likely to be in the small minority who make up the large majority of utilization costs.

Further, the lessons we have learned through past use of telehealth, and are rapidly learning today as we pivot from virtual care encounters being a small minority of care to, in the case of some of us, over 90% of all of our encounters, is that providers are able to make significant interventions in our patient's well-being via a virtual encounter – with video or even a simple audio-only phone call. In other words, a phone call can enable a provider to conduct a meaningful clinical encounter by gathering critical data on patient health, symptoms, concerns, etc. This helps in the widely shared, overarching objective to keep America's Medicare beneficiaries healthy, happy and at home.

As such, creating a broad acceptance for virtual care encounters of any sort (video or voice/audio-only) right now is critical. This is in the best interest of beneficiaries (who will have more engagement with their care provider, more convenience, and fewer access/transportation challenges). It is also in the best interest of the risk-bearing MAOs and MSSP participants (who will achieve better medical management of patients to lower costs and improve future bid cycles), thereby improving CMS' ability to fulfill its mission for the American taxpayer.

To execute this effectively, the important factors are as follows:

1. **During the Coronavirus pandemic, allow providers to use virtual telehealth encounters as an official vehicle to capture or refresh diagnosis codes and update plans of care. If social distancing measures are not in place and it is safe for patients to visit our clinics, a face-to-face visit with the provider will occur within a designated time period to confirm an ongoing physician-patient relationship.**
2. **Ensure the technical requirements for creating an encounter file are as similar as possible to typical office visit encounters so there is no special programming or efforts to create and submit encounters by providers to their MAOs or to CMS.**
3. **For MA, allow MAOs to use data from these virtual telehealth encounters in developing their Risk Adjustment Processing System (RAPS) files <u>and</u> allow the encounters themselves to also count when submitting Encounter Data Processing System (EDPS) risk adjustment files to CMS.**
4. **Create the rule to be retrospective, meaning it should include encounters from the date of the outbreak of coronavirus rather than the date the rule is implemented.**

Telehealth payment:

In addition, we ask CMS to consider the impact of the reduction in payment associated with the place of service differential currently being applied to telehealth.

It is important to understand that each of the signatories to this letter have traditional "brick and mortar" medical practices with the associated infrastructure and operational cost required for the practice of medicine. We are not designed with the lower cost structure of a virtualized service established to only provide telehealth or other remote approaches. Even though the policy to approve telehealth is a strong step forward, the reduction in payment of approximately 30%[1] will have a significant impact to the viability of most medical practices that still rely on visits as a revenue source. Given the unprecedented reductions in volume due to social distancing and isolation recommendations, payment policy is creating a perverse financial incentive to still bring patients into the office. We urge CMS to reconsider and reimburse a telehealth visit at the same levels as a face to face, in office encounter.

We ask that CMS:

1. **During the Coronavirus pandemic, adjust the current telehealth payment methodology to pay telehealth claims at a non-facility rate.**
2. **Make the rules retrospective to allow for telehealth payment to match face-to-face visits on any visit conducted since the coronavirus outbreak rather than only to visits after the rule is established.**

Conclusion

Thank you in advance for your consideration of our comments. We appreciate CMS's attempts to maintain fiscal responsibility across all Medicare programs. We also understand the concern that allowing telehealth visits for risk adjustment diagnoses may raise risk scores and thus costs. However, through coding intensity adjustments and industry averages, this can net out to zero change for CMS for the entirety of the program. With respect to higher payment for the FFS encounter, we believe that the reduction in office visits and the conversion of many to telehealth

[1] We note that the March 17, 2020 press release issued by CMS clearly stated that "Telehealth services are paid under the Physician Fee Schedule at the same amount as in-person services," however under Medicare's current reimbursement methodology that does not hold true. The Medicare Telehealth Frequently Asked Questions (FAQs) also dated March 17, 2020, stated that telehealth encounters are to be paid at the "facility" payment rate differential inherent in the use of Place of Service (POS) code 02 (telehealth) for telehealth claims. The impact of this Place of Service payment differential is reduction of approximately 31%.

visits will either be net neutral or represent a savings in the short term due to the anticipated reduction in traditional Medicare FFS utilization. Meanwhile, these actions would unlock the most innovative providers to get credit and reimbursement at levels that will help protect the viability of their practices while improving the health of Medicare beneficiaries however they see fit, which will lower acute medical care and improve long-term inflation of costs.

We look forward to your rapid action to develop rule(s) that will create stabilization and mitigation through immediate flexibility. This is a solution that helps enable compliance to social distancing – which we expect to be needed for a long time – and better care into perpetuity regardless of social distancing for coronavirus outbreak mitigation.

We are available to you as resource to you as you continue to work to strengthen and improve the MA program. Please do not hesitate to contact us with any questions you may have.

Sincerely,

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