AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

July 7, 20120

VIA ELECTRONIC MAIL
regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: CMS–5531–IFC, Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

Dear Ms. Verma:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) second interim final rule related to the policy and regulatory revisions in response to the COVID–19 Public Health Emergency. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 93 hospitals and more than 300 other health facilities in 16 states and the District of Columbia.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. Due to the differences between our hospitals and their geographic locations, our comments provide an objective and sound policy voice that works for health care as a whole.

We are grateful for the Agency's efforts to provide support and regulatory relief to providers during this pandemic. The waivers addressed in this rule have been of significant value to all of our member hospitals, allowing us to extend health care services outside of the hospital while minimizing exposure to the virus. Our comments below address the following issues:

- Telehealth
- Home Health Services

Telehealth

In the interim final rule, CMS explains the new flexibilities available to hospitals as a result of the waivers provided in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and the Families First Coronavirus Response Act. **AHPA appreciates the clarifications provided in the rule and recommends that the Agency make the following waivers permanent:**

- Allow the provision of Evaluation and Management (E/M) services via audio-only phones, as many Medicare beneficiaries may not have the technology or feel comfortable with the use of video.
- Allow "virtual check-ins" with physicians to be provided to new, as well as established patients.
- Remove frequency limitations on subsequent care services in inpatient and nursing facility settings.
- Allow clinicians to provide remote patient monitoring services for acute conditions, whether for COVID-19 or for another condition.
- Allow health care professionals who were previously unable to furnish and bill for Medicare telehealth services (including physical therapists, occupational therapists, speech language pathologists and others) to receive payment for these services by expanding upon the definition of "practitioners."
- Allow hospitals to bill for therapy, education and training services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home.
- Remove the originating site requirements for telehealth.
- Waive the requirement that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state.
- Allow Medicare Advantage (MA) organizations to submit diagnoses for risk adjustment from telehealth encounters.
- Remove any requirement that the patient be an "established patient" and allow providers to establish care using telehealth for new patients by removing this language in the code descriptors.
- Exempt providers providing telehealth from enrolling their homes as a practice location when services are provided from the provider's home or have a modified enrollment process in place for the same.
- Allow providers to provide direct supervision using telehealth.

AHPA recognizes that Congressional action will likely be needed to make some of these changes permanent. However, we encourage the Agency to work collaboratively with Congress in this effort and make changes where it has existing authority through the rulemaking process. Prior to COVID-19, health systems were already redesigning their delivery of care with the consumer in mind. This included ensuring that consumers were receiving care at the right time and place, bringing services closer to their home. Although telehealth was seen as central to this effort, statutory and regulatory barriers made it difficult to adopt telehealth widely. The flexibilities provided as a result of the COVID-19 pandemic made it possible for providers to fully embrace telehealth. Hospitals across the nation are now able to connect individuals with various specialists from the comfort of their homes; better manage the chronic conditions of patients through remote patient monitoring; and improve patient outcomes by expediting access to medical treatment. The progress made through this type of delivery of care cannot be squandered. As COVID-19 continues to challenge us, telehealth can reduce patient exposure to the virus while also increasing access to care. Below we outline some of the experiences of our member hospitals and the benefits enjoyed by patients as a result of the waivers granted.

- **Increased access to behavioral health services.** Telehealth has allowed hospitals to expand access to behavioral health services despite the shortage of behavioral health professionals across the country. It has proven to be an effective tool, as it helps to reduce the stigma and potential discomfort that many individuals experience when walking into an office for behavioral health services. Additionally, telehealth has allowed hospitals to better reach patients, such as those with substance use disorder, that would normally avoid the hospital setting. The COVID-19 pandemic and the resulting economic downturn have adversely impacted people's mental health, with the effects likely to be felt for years to come.[1] This, combined with the U.S. shortage of behavioral health professionals, makes coverage of telehealth services essential for the future.

- **Faster access to treatment and specialized care.** Telehealth has allowed hospitals to connect patients with an array of specialists who may not be locally available during a patient's hospitalization (i.e. neurology, endocrinology, rheumatology, cardiology). This has expedited access to needed medical treatment and reduced the need for patient transfers to other facilities.

[1] Henry J. Kaiser Family Foundation. The Implications of COVID-19 for Mental Health and Substance Use.

- **Better management of chronic conditions.** Through telehealth, hospitals have been able to offer a variety of services such as diabetes self-management education, medical nutrition therapy and coaching. As an example, patients have been able to select food from in their home and learn how to read labels with an educator. Patient surveys have been significantly positive and highlighted patient's desire to continue to receive education in this manner.

- **Improved follow-up care, preventing lapses in care.** Some hospitals have used telehealth to monitor the health of patients discharged from the Emergency Department. At AdventHealth, headquartered in Florida, patients were discharged home with a telecommunication device to daily answer questions about symptoms and record temperature. Patients also had the ability to text with a nurse or request a video visit. This improved follow-up care has helped reduced missed appointments and avoid lapses of care.

- **Expanded hospital capacity through Hospital-at-Home model.** Adventist Health, located in California, launched a new Hospital-at-Home model that provides a flexible tool for managing waves of potential COVID-19 outbreaks in nine Adventist Health service areas. Hospital-at-Home models increase the ability of hospitals to treat more patients by freeing valuable acute care beds and allowing patients in need of less intensive care to be treated in the comfort of their home.

While there are still many barriers, such as state licensing laws, that limit the widespread use of telehealth, we believe that the permanent adoption of the COVID-19 waivers would accelerate the innovations already taking place via telehealth. Telehealth serves as an option to provide health care services to patient populations that are more vulnerable to the virus, such as the elderly, pregnant women and those with existing chronic conditions or limited mobility. Reinstituting the telehealth restrictions that existed prior to the pandemic would be a missed opportunity to expand access to care, ensure the continuity of services currently provided through telehealth and build the needed infrastructure to prepare for future pandemics.

The interim final rule also adds multiple services to the Medicare telehealth list, allowing payment to be made for those services. As an example, CMS added emergency department evaluation and management (E/M) codes 99281-85, observation and discharge day management codes 99217-20, 99224-26, 99234-36, and critical care services codes 99291-92, to the telehealth services list. AHPA supports the addition of these services and recommends that they be reimbursed permanently. **We also recommend that the**

Agency further expand the list of telehealth services reimbursed during the COVID-19 pandemic under the physician fee schedule, making reimbursement permanent and not just related to the public health emergency.

Homebound Definition

In the rule, CMS clarifies that patients will be considered homebound if it is medically contraindicated for them to leave home due to the pandemic, including because of confirmed or suspected COVID-19 or because leaving the home would make a patient more susceptible to contracting COVID-19. The Agency seeks comments on this clarification, asking whether the exemption should be limited just to the COVID-19 pandemic.

AHPA strongly recommends that CMS make this exception permanent after the end of the public health emergency for any patient whose medical condition makes it more medically appropriate to receive care at home. Given the vulnerability of the elderly to COVID-19, CMS should also consider eliminating the "homebound" requirement for home health services. Regardless of whether an individual currently meets the criteria of "homebound," Medicare beneficiaries are more likely to develop serious complications from COVID-19, making the home a more secure place for receiving health care services.

Coverage of Telehealth Services

In its 2021 Home Health Prospective Payment System proposed rule, CMS proposes to make permanent the use of telecommunication technologies in providing care to Medicare beneficiaries receiving home health services. However, the rule states that these services would not be reimbursed by Medicare.

AHPA commends the Agency for the proposed change but recommends that reimbursement be provided for the use of telehealth. Without such reimbursement, many Medicare beneficiaries will be unable to experience the benefits of telehealth. Telehealth allows providers to more effectively manage a patient's ongoing care through more frequent interactions and facilitates the ability of caregivers to participate in the clinical visits. While we believe that telehealth should not replace all in-person visits, it will minimize the frequency of such visits and consequently reduce a beneficiaries' exposure to the virus and the need for limited personal protective equipment. The investments made by providers to acquire the telecommunications technology, train their clinical team and provide the telehealth services needs to be adequately reimbursed.

Providers Ordering Home Health Services

The rule expands the provider types who can order home health services. For the duration of the COVID-19 emergency, CMS is allowing licensed practitioners, including Nurse Practitioners (NPs) and Physician Assistants (PAs), to order home health services. This flexibility applies to home health nursing and aide services, medical supplies, equipment and appliances, and physical therapy, occupational therapy, or speech pathology and audiology services.

AHPA urges the Agency to extend this waiver after the end of the public health emergency. These provider types are increasingly providing primary care for the home care population and are necessary in many geographic locations, particularly in rural areas with physician shortages.

Conclusion

AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Susana Molina, Manager of Public Policy, at Susana.MolinaRamos@AdventHealth.com.

Sincerely,

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President
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