June 4, 2020

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
U.S. Capitol Building S-230
Washington, DC 20210

The Honorable Nancy Pelosi
Speaker
U.S. House of Representative
U.S. Capitol Building H-222
Washington, DC 20215

The Honorable Charles E. Schumer
Democratic Leader
U.S. Senate
U.S. Capitol Building S-221
Washington, DC 20510

The Honorable Kevin McCarthy
Republican Leader
U.S. House of Representatives
U.S. Capitol Building H-204
Washington, DC 20515

Dear Majority Leader McConnell, Speaker Pelosi, Leader Schumer and Leader McCarthy:

On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 175,000 other provider organizations, we applaud your leadership in enacting the *Coronavirus Preparedness and Response Supplemental Appropriations Act,* the *Families First Coronavirus Response Act,* the *Coronavirus Aid, Relief, and Economic Security (CARES) Act* and *the Paycheck Protection Program and Health Care Enhancement Act*. The relief funds and loans for providers, enhanced payments for caring for COVID-19 patients and the expansion of telehealth and other critical provisions have helped our members shift their care practices while remaining financially stable for the short-term.

These actions have significantly improved healthcare providers' ability to combat the epidemic. Specifically, waivers that are made possible under Section 1135 of the Social Security Act have allowed healthcare providers to rapidly shift the way care has been delivered. Additionally, the COVID-19 epidemic was a pressure test of how to modernize and improve healthcare. As health systems and providers continue to support their communities in the reopening phases, providers are concerned that a retreat to prior rules will limit provider care delivery innovation. Accordingly, we request that you help ensure that the progress that has been made in transforming the healthcare delivery system is maintained. Below are provisions that we urge Congress to adopt to ensure we innovate care and accelerate the movement to value-based care.

Providing Permanent Flexibility for Telehealth. We greatly appreciate that the CARES Act expanded the Secretary's Section 1135 emergency waiver authority to include all aspects of telehealth**. This allowed beneficiaries outside of rural areas to receive telehealth services in their home from an expanded set of providers.** Currently Section 1834 (m) of the Social Security Act severely limits the provision of telehealth to rural providers and still requires a beneficiary to travel to an originating site. Statute also specifies the types of practitioners who are eligible to furnish and bill for telehealth services. As a result, several types of practitioners, such as physical and occupational therapists, are excluded from providing telehealth services despite being able to safely and effectively administer the same services remotely.

With major advances in technology since this provision was first enacted and significant changes in how care is delivered, it is essential to expand telehealth services within Medicare. According to a survey[1] of health systems administered last month[2], 93 percent of respondents cited this waiver as essential to make permanent.

Moreover, the current statutory requirements put Medicare beneficiaries at a disadvantage to patients with commercial insurance. For example, many private payers have implemented a variety of telehealth programs allowing patients to consult practitioners before going to an emergency department (ED), have routine follow-up visits and seek behavioral health services from home. These efforts lead to a reduction in ED utilization and hospitalizations while also maintaining patients at a current or lower level of risk.

With similar allowances in place during the public health emergency, providers have rapidly deployed similar initiatives. **We ask that you revise the telehealth statute by removing the originating site, rural and types of eligible practitioners requirements as well as granting CMS greater authority to set regulation on allowable health services and payment.** We believe this approach will allow a metered progression to telehealth. CMS could make changes to allow telehealth services and monitor for impacts on overall Medicare spending and program integrity prior to additional expansions. Additional guardrails could be put in place, such as limiting the amount of telehealth payment in initial years and regular reporting by the Secretary. The existing notice and comment rulemaking will also allow stakeholders to weigh in on the types of services that should be covered and the associated costs. Finally, this would also give CMS the ability to provide greater flexibility within alternative payment models (APMs). While telehealth waivers are available for APMs, they are far more limited than the waivers provided during the public health emergency. Providing greater flexibility in models can incent the transition from fee-for-service to value.

Modify the Emergency Medical Treatment and Labor Act (EMTALA). The 1135 emergency waiver authority has allowed the Secretary to waive enforcement of EMTALA. In response to the current public health emergency the Secretary allowed hospitals to redirect patients who present at the ED to an alternative screening site and to transfer individuals with an unstable emergency medical condition. To use these waivers, many health systems relied on technology to screen patients upon ED arrival. Outside of a public health emergency, such screening tools would not typically meet the medical screening requirements under EMTALA. These tools are essential for avoiding unnecessary hospitalizations for ambulatory conditions, estimated to cost more than $2,000 per visit.

While EMTALA is necessary to ensure that all patients have access to emergency medical care, **we urge Congress to revise the statute to allow for new types of medical screenings.** Specifically, many health systems hope to employ pre-screenings that use technology that can help divert non-emergent cases to other settings. The current medical screening requirements are so extensive that patients remain in the full queue of ED patients before it is determined that they could be diverted to another setting of care. More often than not, the patient is treated in the hospital after long wait times rather than being directed to nearby outpatient departments or physician practices, where the patient could have received appropriate care in a more timely manner and at lower cost to the patient and healthcare system. We envision appropriate guardrails could be put in place by requiring hospitals to have their pre-screening approaches approved by CMS and requiring additional data submissions on patient diversion.

---

[1] https://www.premierinc.com/newsroom/press-releases/premier-inc-survey-clinically-integrated-networks-in-alternative-payment-models-expanded-value-based-care-capabilities-to-manage-covid-19-surge

13034 Ballantyne Corporate Place T 704.357.0022
Charlotte, NC 28277 F 704.357.6611
444 North Capitol Street, N.W. T 202.393.0860
Suite 625, Washington, DC 20001 F 202.393.6499
PREMIERINC.COM

Ensuring Continued Movement to Value-Based Care. The pandemic has required greater care coordination across the traditional healthcare silos as providers work to manage infected patients in the most effective settings. According to a Premier survey, leading health systems and providers operating in value models were able to rapidly implement strategies to respond to COVID-19, expanding care management, call centers and remote/home monitoring and other capabilities to respond to COVID-19. Moreover, if we had made more progress in value-based care prior to COVID-19, with more entities in global budgets or capitation, we could have avoided the financial challenges many providers faced. We urge Congress to support a continued emphasis on movement to value by:

- Incenting providers to move to downside risk arrangements by extending the Advanced APM bonus by five years and giving CMS the authority to set the thresholds to qualify for the bonus;
- Including the Accountable Care in Rural America Act (H.R. 5212) and The Rural ACO Improvement Act (S. 2648) in the next legislative package; and
- Removing risk adjustment caps from value models so that the complexity of patients is recognized in the benchmark.

We remain committed to working with Congress to address the COVID-19 pandemic and its aftermath. Contact Duanne Pearson, Vice President, Advocacy) at duanne_pearson@Premierinc.com or 202.879.8008 with questions or for more information.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier Inc.