PREMIER TRANSFORMING HEALTHCARE TOGETHER®

June 4, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Regulatory flexibilities to maintain post COVID-19 Public Health Emergency

Dear Administrator Verma:

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 the rapid response of the Centers for Medicare & Medicaid Services (CMS) to the coronavirus pandemic. The policies and waivers CMS has put in place have been essential tools in ensuring that providers are able to adapt their care processes to continue maintaining the health of beneficiaries.

We greatly appreciate that the Administration has signaled its interest in extending certain flexibilities beyond the public health emergency. Many of the waivers and temporary regulatory changes granted during this period have highlighted key opportunities to modernize healthcare delivery by removing outdated regulations. Below we have highlighted several policies that Premier recommends CMS adopt as permanent changes to the Medicare program. We also request that you help ensure that the progress that has been made in transforming the healthcare delivery system does not regress toward an emphasis on fee-for-service care. Leading health systems and providers operating in value models were able to rapidly implement strategies to respond to COVID-19, coordinating with local providers, expanding telehealth and diverting care coordinators to help manage patient outcomes. We believe some of these flexibilities could be incorporated into alternative payment models (APMs) in order to incent the transition from fee-for-service to value.

MODERNIZING THE TELEHEALTH BENEFIT

Telehealth has been a critical tool during the public health emergency, allowing providers to continue to furnish much needed services to patients from the safety of their home. The flexibilities that CMS has granted around telehealth have served to highlight that many services can be effectively and efficiently furnished remotely. Moreover, according to a Premier survey[1] of health systems administered last month, 93 percent of respondents supported making these waivers permanent.

Several Medicare requirements restrict providers from adopting telehealth more broadly outside the emergency period. While we have encouraged Congress to modify the telehealth statute to allow for broader access to telehealth services, we believe there are several actions that CMS can take to improve telehealth, including allowing greater flexibility around the types of technology that can be used, adopting additional services, and exploring additional flexibilities through Innovation Center models. Many private payers mirror the flexibilities and coverage policies provided by Medicare. As a result, it is important that CMS moves quickly to adopt these changes, which will have lasting effects on both Medicare and healthcare delivery more broadly.

[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

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Technology. As part of the public health emergency, CMS waived requirements to allow for certain services to be furnished through audio-only technology. Accessing video technology can be particularly challenging and create barriers for beneficiaries who are low-income, elderly, or who live in rural areas where the broadband infrastructure cannot support streaming video. These challenges will persist even after the emergency period. The public health emergency has highlighted that many services can be effectively delivered as audio-only and do not require a video-connection. As a result, ***we encourage CMS to maintain flexibilities to allow certain services to be furnished via audio-only telehealth.*** Specifically, CMS should modify its definition of "interactive telecommunications system" (410.78(a)(3)) to allow for use of audio-only technology for services where it would be clinically appropriate. CMS could continue to differentiate which services are eligible to be furnished via audio-only as compared to those that require both audio and video technology. CMS should provide stakeholders with the opportunity to weigh in on these lists as part of annual rulemaking.

As part of the first interim final rule, CMS clarified for the duration of the public health emergency that telephones with video capabilities (e.g., smartphones) can meet the definition of interactive telecommunication technology. Currently, regulation states that "telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system." This has caused some confusion for providers since some patients may have mobile telephones that have video capabilities that would otherwise meet the definition of interactive telecommunication technology. ***We encourage CMS to revise its regulation to clarify that telephones with video capability can meet the definition of interactive telecommunication.***

Finally, we encourage CMS to work with the HHS Office of Civil Rights (OCR) to provide additional guidance on types of technologies that would be considered HIPAA-compliant. As part of the public health emergency, OCR is practicing enforcement discretion and will not sanction providers who furnish telehealth services using non-HIPAA compliant technologies. Reforming the telehealth benefit will result in more providers being able to furnish services, many of whom may not be familiar with what would be considered a HIPAA-compliant technology. As a result, CMS and OCR should provide guidance on types of technologies that are already HIPPA-compliant or the features that technology must have in place to be compliant. Additionally, the burden of compliance should not be on the provider, but rather on the vendor. As a result, OCR should update its guidance and regulations so as to not penalize providers who may accidentally use non-compliant technology if the provider acting in good faith believed the technology to be compliant to the best of their knowledge.

Telehealth and Risk Adjustment. On April 10, CMS released guidance indicating that Medicare Advantage plans and other organizations can submit risk-adjusted data obtained through telehealth visits during the public health emergency. ***CMS should continue to allow for diagnoses obtained through telehealth to be used for risk adjustment purposes under the Medicare Advantage program, accountable care organizations, and the individual and small group markets.*** This will be particularly important with wider telehealth adoption to ensure providers are able to fully capture the health needs of its patient population.

While the April 10 guidance only applied to diagnosis codes collected through telehealth services utilizing both audio and video technology, CMS should extend this policy to also include services furnished via audio-only telehealth. In most situations, particularly for established patients, providers can adequately confirm diagnoses over audio-only technology using patient history and a discussion or analysis of symptoms, labs, and vital signs, which may be taken by a patient at home.

Additional telehealth services. CMS has temporarily added more than 130 new codes to the list of services that are eligible to be furnished via telehealth. We urge CMS to work with stakeholders to identify which telehealth services should continue after the public health emergency. Priority areas should include behavioral health and physical and occupational therapy follow-up.

Opportunities for Innovation Center Models. CMS should continue the following telehealth flexibilities through Innovation Center waivers for to those providers participating in APMs:

- *Frequency limits*. As part of the public health emergency, CMS waived frequency limits on certain services furnished via telehealth: subsequent hospital care, subsequent nursing facility care, and critical care consultation services. Under a fee-for-service construct, these limits may help ensure patients receive proper in-person care and that bad actors do not abuse billing for these services. However, these concerns are mitigated when providers are held accountable for the cost and quality of care through APMs. As a result, CMS should continue to waive frequency limits for those providers participating in APMs.
- *Established patient requirements*. Several of the virtual and telehealth services require that a patient receive in-person services from a practitioner within a certain time period in order to be eligible for services to be delivered remotely. Under the public health emergency, CMS waived many of these requirements to allow practitioners to furnish virtual and telehealth services to both established and new patients. We encourage CMS to explore removing or revising these requirements around established patients to allow practitioners to furnish services to new patients. For example, there may be instances where a provider, such as a specialist, could furnish appropriate services to a new patient through telehealth or other virtual services. At a minimum CMS should maintain this waiver for certain APMs where beneficiaries voluntarily align or are prospectively assigned to an APM participant.

Telehealth and other remote services furnished by other providers. The public health emergency has highlighted the effectiveness of furnishing services via telehealth across multiple providers. CMS has granted flexibilities to allow for post-acute care providers to furnish additional services remotely, such as allowing home health agencies to use technology to furnish more services within an episode of care. Additionally, CMS has also waived certain conditions of participation and provider-based requirements to allow hospitals to furnish services to patients in their home remotely. While these outpatient services are not technically considered telehealth services, they are furnished in the same manner as telehealth services. Several of the services are also similar to services that can be furnished by physicians through telehealth.

Telehealth services are usually billed on a professional claim, which has been a limiting factor for allowing other types of providers to furnish telehealth services, even under the public health emergency. In some cases, services furnished via telehealth would be captured in an episode and included in a Medicare payment. However, there are other instances where providers would not be paid for services furnished remotely. ***We encourage CMS to continue to explore what regulatory and statutory changes are necessary to allow other provider types, such as institutional providers, to allow to furnish and bill for telehealth services.***

STREAMLINING WORKFORCE REQUIREMENTS

As part of the public health emergency, CMS waived several requirements related to scope of practice to ensure providers can fully maximize their workforce. For example, CMS waived requirements that a certified registered nurse anesthetist be under the supervision of a physician. These waivers had the effect of deferring policy to state laws and requirements related to supervision and licensure.

Oftentimes, Medicare scope of practice requirements are duplicative of existing requirements at the state level and, in some cases, may be more stringent. This can be overly burdensome to providers as they track various requirements to ensure compliance. ***As part of its Patients Over Paperwork initiative, CMS***

should explore streamlining its scope of practice requirements to remove unnecessary and overly burdensome requirements that are duplicative of state or licensing board efforts.

Additionally, in the first interim final rule, CMS revised the definition of direct supervision for the duration of the public health emergency to allow for direct supervision to be provided using real-time interactive technology that audio and video capability, or a virtual presence. Direct supervision requires that a physician or other practitioners be immediately available when services are being furnished to Medicare beneficiaries. Advances in technology allow physicians and other practitioners to stay connected virtually, which in some cases may be more expeditious and efficient than if the practitioner was physically present**. We encourage CMS to provide practitioners with the discretion to determine the best means of providing appropriate direct supervision**. At a minimum, CMS should explore allowing direct supervision to be met through virtual presence for certain services.

INNOVATION CENTER MODELS.

Several of the waivers under the public health emergency warrant additional testing through Innovation Center models or through adjustments to existing waivers.

SNF 3-Day Rule. CMS has waived the requirement that Medicare beneficiaries have a 3-day hospitalization in order to be eligible for skilled nursing facility (SNF) services under the public health emergency. The Medicare Shared Savings Program (MSSP) and several Innovation Center models utilize a similar but more burdensome waiver. Under these existing waivers, providers must meet certain documentation requirements and are only eligible for the waiver if patients are discharged to certain facilities. CMS should streamline the Innovation Center and MSSP waivers to match the waiver granted under the public health emergency. Additionally, CMS should utilize data it has collected from these models and MSSP to evaluate whether the SNF 3-Day rule should be removed from Medicare statute completely.

Hospital at Home. CMS has waived several conditions of participation and provider-based rules to allow for hospitals to furnish services in a patient's home both remotely and in-person. As part of the second interim final rule, CMS acknowledged that facility staff can effectively furnish certain outpatient therapy, education, and training services using telecommunication technology. Additionally, CMS acknowledged other types of outpatient services that could be furnished by clinical staff in a patient's homes, particularly services that may only require general supervision and are not primarily surgical in nature. The public health emergency has highlighted that certain outpatient services can be furnished safely and effectively in a patient's home. We encourage CMS to develop a new alternative payment model or adapt existing alternative payment models to further test the hospital at home concept.

Rural Hospitals. CMS waived several requirements around rural hospitals, such as requirements for CAHs that limit number of beds to 25 and average length of stay to 96 hours. As CMS continues to explore new rural-focused models, CMS should consider waiving such requirements to provide rural hospitals with additional flexibilities to redesign care delivery under these models.

OTHER POLICIES

Utilization Reviews. CMS waived conditions of participation that specify the processes that a hospital must have in place to conduct utilization reviews. These requirements are duplicative and may be overly burdensome for hospitals that are participating in population health activities that are focused on ensuring patients receive high-quality and efficient care. Additionally, some hospitals employ technologies that automate appropriateness reviews, such as through prior authorization. We urge CMS to allow for hospitals

to be exempt from this condition of participation if they have other mechanisms in place to review utilization and medical necessity of care, CMS could employ a certification process for other mechanisms.

Discharge Planning Requirements. CMS waived certain requirements that hospitals, home health agencies and long-term care facilities assist patients and their families in selecting post-acute care providers by using and sharing data that includes quality and resource use measures. This requirement, as well as several others around discharge planning, were finalized this past fall and went into effect in late November 2019. Even when the pandemic has subsided, providers will continue to face many challenges with adjusting to a new normal. CMS should consider allowing for a longer transition for providers to meet these new requirements and should allow for additional flexibilities in how these requirements are met. For example, CMS should consider allowing requirements to be met electronically when appropriate.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit our recommendations on flexibilities and reforms that should continue after the COVID-19 public health emergency. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, Vice President, Policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier Inc.