Health. Virtually. Everywhere.

November 3, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Comments on the Centers for Medicare and Medicaid Service (CMS) Request for Information "Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs"

Dear Administrator Brooks-LaSure,

The American Telemedicine Association (ATA), the only organization focused solely on advancing telehealth with over 400 member organizations, and ATA Action, the ATA's affiliated trade association focused on advocacy, appreciates the opportunity to provide feedback on the RFI and the impact of the COVID-19 waivers and flexibilities on the telehealth industry. We applaud the Administration for acting swiftly during an unprecedented time to ensure millions of patients had access to care where and when they needed it.

ADVANCING HEALTH EQUITY

Telehealth, when utilized in accordance with health equity principles, can eliminate disparities and inequities in health. The U.S. has entered a period where the subject of disparities is receiving a historic level of attention by government and market stakeholders. This focus and the collective energy that accompanies it is welcome after decades of widening socioeconomic gaps across American communities and well-documented disparities in health among rural/urban communities, communities of color, and tribal nations. It is against that backdrop that the ATA organized the CEO's Advisory Group on Using Telehealth to Eliminate Disparities and Inequities to develop and advance the ATA's Framework for Eliminating Health Disparities Using Telehealth. This framework recognizes the need to ensure connectivity, health literacy, and digital literacy in order to increase access and reduce disparities. Further, the framework notes the need health professionals to have technical skills and cultural awareness to support optimal patient care with an underlying philosophy of inclusiveness. It is with these principles in mind that telehealth providers should seek to provide care in a nondiscriminatory way and reduce health disparities. As the model advances, perhaps a facet that should be considered more closely is the way in which the technological and structural infrastructure should support nondiscrimination.

While telehealth is part of an imperfect health care system and barriers persist to ensuring that everyone has access to the health care they need whether in person or virtually, we believe that integrating virtual care offerings fully into the health care ecosystem and making virtual services available to those who need them will bridge the gap that the traditional health care system has not yet been able to when it comes to addressing health disparities.

ATA ACTION
901 N. Glebe Road, Ste 850 | Arlington, VA 22203
Info@ataaction.org

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IMPACT OF COVID-19 PHE WAIVERS AND FLEXIBILITIES

As you know, telehealth has been a lifesaver for millions of Americans across the United States during the COVID-19 pandemic. Under the COVID-19 public health emergency (PHE):

- the geographic and originating site restrictions have been waived meaning Medicare beneficiaries have been able to receive care virtually in any geographical location (rural, urban, suburban) and within the comfort of their home
- the list of eligible providers that can provide telehealth services has been expanded to include physical therapists, occupational therapists, speech language pathologists, and audiologists
- the 1,400 Federally Qualified Health Centers (FQHCs) and the 4,300 Rural Health Clinics (RHCs) can furnish telehealth services
- telemental health services can be furnished without a prior in-person visit
- audio-only services are covered
- the Hospital Without Walls program was implemented, allowing hospitals to provide services in locations beyond their existing walls such as ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories, among other locations, while receiving hospital payments under Medicare.
- new temporarily allowable Medicare telehealth codes were added
- provider enrollment fees and requirements were waived
- the definition of direct supervision was modified to include virtual physician presence through audio/video real-time communications technology when indicated to reduce exposure risks.
- RPM services have been allowed to be delivered to new patients along with established patients and the number of days required for data collection was shortened

Due to the telehealth waivers and flexibilities granted in the beginning of the pandemic, more than 28 million Medicare beneficiaries—about 2 in 5—used telehealth services in 2020[1]. This number has since decreased but is still above pre pandemic levels.[2] Importantly, the temporary expansion improved access to telehealth for Medicare beneficiaries especially for older American and the medically underserved.[3] Overall, patients and providers have grown to love telehealth and want to continue using these tools in the future.[4] In addition, OIG reported a very small proportion of providers (1,714 providers out of approximately 742,000) billed Medicare inappropriately, indicating that the measures put in place to safeguard against fraud, waste, and abuse related to telehealth worked well to maintain program integrity.[5] Subsequently, it is imperative that CMS urges Congress to make the telehealth flexibilities implemented during the

[1] https://oig.hhs.gov/oei/reports/OEI-02-20-00522.pdf
[2] https://www.gao.gov/assets/gao-22-104454.pdf
[3] https://www.medrxiv.org/content/10.1101/2022.06.15.22276468v1
[4] https://www.americantelemed.org/wp-content/uploads/2022/02/Patients-Providers-and-Plans-Increase-Utilization-of-Telehealth-Recent-Stats-2.18-2.pdf
[5] https://oig.hhs.gov/oei/reports/OEI-02-20-00720.pdf

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PHE permanent to ensure that patients across the U.S. do not lose access to these critical services.

RECOMMENDATIONS FOR CMS POLICY AND PROGRAM FOCUS AREAS

For ATA's Recommendations, please visit the following link: (Page 1: FFS Congressional action; Page 2-5: FFS and MA Regulatory Action) https://www.americantelemed.org/wp-content/uploads/2020/08/ATA-Action-Permanent-Policy-Recommendations-Chart_Updated-6.29.22.pdf

In addition to the recommendations in the above chart, under the 1135 waiver the Acute Hospital Care at Home program was created which allows hospitals to render at-home care and services to patients with acute conditions that would typically be treated in an inpatient setting by waiving CMS's 24-hour on-site nursing requirement for hospitals that participate in Medicare. This care delivery model has proven to lower costs and increase patient health outcomes and satisfaction. Medicare and Medicaid patients who receive at-home care through CMS's Acute Hospital Care at Home program risk losing access to this patient-centered care delivery model if no action is taken to protect the program. We urge CMS to use its existing authority and work with Congressional leaders to understand the value of this program and ultimately make this program permanent to ensure patients can continue receiving critical healthcare services daily within the comfort and safety of their homes to treat their acute diagnoses when clinically appropriate. For more information, see ATA's Acute Hospital Care at Home Program One-Pager.

Also, CMS does not require the collection of data on the use of telehealth through the hospice claim form, no consistent information on the use of telehealth, and its impact on patient access and quality, is being gathered. Hospice providers need the opportunity to reflect the full scope of care provided to patients experiencing serious illness. Right now, care delivered through telehealth is not measured, and therefore, many visits are not noted in any official record. This means that patients' records fail to reflect the full scope of care they receive, and hospice organizations are left without a way to fully capture the quantity of their patient visits and quality of their work. We urge CMS to develop and implement HCPCS codes or modifiers for telehealth visits and add them to the hospice claim form.

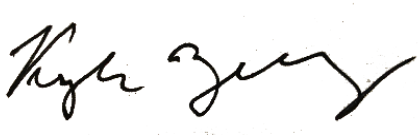
Lastly, during the COVID-19 Public Health Emergency, the Drug Enforcement Agency (DEA) waived the in-person requirement for the prescription of controlled substances. Both established and new patients across the U.S have been able to receive treatment and prescriptions within the comfort of their homes helping to increase access, reducing the stigma associated with going to visit a provider in-person and eliminating barriers such as the cost of transportation or childcare. This flexibility will end with the COVID-19 PHE unless action is taken. The use of telehealth during the pandemic was associated with improved retention in care and reduced odds of

medically treated overdose, providing support for permanent adoption.[6] Therefore, we urge CMS to work with its colleagues at the DEA and on the Hill to ensure patients do not lose access to critical treatments after the PHE. See here for the ATA's Recommendations on Ensuring Appropriate Treatment and Protecting Patients Through Online Prescribing.

Thank you for the opportunity to provide feedback on this RFI. We look forward to collaborating with your team now and in the future. If you have any questions or would like to further engage in an additional discussion regarding the telehealth industry's perspective, please contact me at kzebley@ataaction.org.

Sincerely,

Kind regards,



Kyle Zebley
Executive Director
ATA Action

[6] Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic | Substance Use and Addiction Medicine | JAMA Psychiatry | JAMA Network

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