



December 31, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of the National Coalition on Health Care (NCHC), we appreciate the opportunity to comment on Centers for Medicare and Medicaid Services' (CMS)' "Medicare and Medicaid Programs: Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service and Medicaid Managed Care Programs for Years 2020 and 2021" (CMS-4185-P).

NCHC is the largest, most broadly representative nonpartisan alliance of organizations focused on improving health care. The Coalition is committed to advancing—through research and analysis, public education, outreach, and informed advocacy—an affordable, high-value health care system for all Americans. Our members and supporters include more than 80 of America's leading associations of health care providers, employers and unions, consumer and patient advocacy organizations, pension and health funds, religious denominations, and health plans.

NCHC limits its comments to the proposed rule's discussion of expanding Part C telehealth benefits.

Requirements for Medicare Advantage (MA) Plans Offering Additional Telehealth Benefits

Under current MA benefit rules, plans can only offer telehealth services through real-time communication technology that meet the strict geography and patient setting requirements or offer telehealth services that did not meet those requirements as "supplemental benefits," generally paid for via supplemental enrollee premiums.

The proposed rule will codify portions of the February 2018 Bipartisan Budget Act (BBA) that will, in part, allow Medicare Advantage (MA) plans to offer telehealth benefits such that:

- As a basic benefit instead of a separate supplemental benefit beginning in plan year 2020.
- Basic benefit telehealth services would be limited to remote access technologies and/or telemonitoring services for which benefits are available under Medicare Part B.
- If the MA plan offers or covers expanded telehealth benefits the plan must also provide access to such services through an in-person visit as well. That is, the enrollee would have the option whether to receive such service via an in-person visit or as a telehealth benefit.
- Plans would be excluded from additional health benefits any capital and infrastructure costs as

investments related to these benefits.

- The proposed rule seeks comment on whether CMS should place any limitations on what types of Part B items and services should be defined as a basic telehealth benefit.
- Plans that choose to offer telehealth services as a basic benefit must annually disclose these benefits offered under a plan, including applicable conditions and limitations, premiums and cost sharing.
- CMS estimates additional telehealth benefits under MA will impact between 21 and 29 million beneficiaries annually, account for 2.5 percent to 5.4 percent of annual care visits and save beneficiaries in travel time annually between \$60 million and \$152 million.

General Comment

Like the three-day hospital stay requirement for admission to a Skilled Nursing Facility, CMS' current limitations on the use of telehealth services are antiquated. Per a November report to the Congress, CMS estimated that in 2016 only 0.25 percent of Medicare beneficiaries were able to exploit a telehealth service.

Telehealth services have been in use for approximately 40 years, predominantly in the private payer insurance market. They can and do fundamentally change or disrupt the way healthcare is delivered since they offer numerous methods and modalities to expand care delivery capacity, efficiency and improve health care outcomes particularly in under-served and rural areas. Telehealth, whether it be synchronous or asynchronous, offers the ability to enhance consultations between patients and providers, enable remote monitoring, improve the transmission of medical information, help support patient self-management and generally improve communication and education between specialty and primary care providers and providers and patients. In primary care, telehealth applications have a myriad of uses in preventing or managing numerous leading causes of illness, disability and death. In sum, telehealth services facilitate prevention, coordination and cure and deserve to be equally available to all Medicare beneficiaries.

Studies of telehealth's use in primary care for example show it is cost effective in reducing hospital admissions and re-admissions as well as reductions in both emergency visits and transfers between emergency departments. Studies also show telehealth services are less expensive, are not additive, they are moreover a substitute for in-person care, and are unlikely to induce utilization. Concerning quality of care, systematic reviews show telehealth has had a significant positive effect for several predominate diseases, for example, heart disease and psychiatric conditions. Patient satisfaction via the use of telehealth, more specifically interactive video, telephone consultations and remote monitoring, has on balance been high.

As is well noted, the Veterans Administration (VA) and its patients continue to benefit substantially from telehealth care. Well over on million veterans annually use some type of VA telehealth offering. The VA expects this number to increase to over four million, or two-thirds of all veterans receiving some form of VA health care, in the near future. VA use of telehealth includes a host of counseling services, prosthetic and other check-ups and the sharing of electronic medical record access for veteran family caregivers.

Another essential use of telehealth is remote patient monitoring (RPM) as a way of providing secondary prevention for patients with chronic illness. RPM use to monitor VA patients with chronic obstructive pulmonary disease, congestive heart failure, diabetes and other chronic conditions has shown a reduction in hospital bed days of care in excess of 40 percent on pre-enrollment figures. RPM

use by the VA has also led to an 80 percent decrease in nursing home admissions and a 66 percent reduction in emergency department visits. The VA reports its telehealth programming generally has among other things reduced overall bed days for veterans by over 50 percent and hospital admissions by 40 percent.

Similar results in the use of so called consumer-facing technologies have been achieved in the private sector. For example, cardio-vascular disease patients in Boston's Partners Healthcare receiving RPM services experienced a 50 percent reduction in related hospital re-admissions. Similar results were achieved for Colorado patients enrolled in Centura's Health At Home program. In sum, an October 2014 Office of the National Coordinator on HIT noted in a paper titled, "Health Information Technology Infrastructure To Support Accountable Care Arrangements," expanded remote monitoring would produce as much as \$200 billion in cost savings over the next quarter century.

As noted above the use of telehealth may be particularly beneficial in rural communities. For example, the Indian Health Service (IHS) has used both live video conferencing and asynchronous technologies to improve Native American health in particularly remote locations. For example, the IHS has been successful in improving diabetes control by significantly lowering low-density lipoprotein cholesterol and hemoglobin A1c levels. The IHS has also used the technology to consult with specialists throughout the country to improve its delivery of specialty care.

Despite considerable favorable evidence, telehealth remains largely more promise than product. Likely the most rudimentary use of telehealth is electronic communication or e-visits. Studies show these encounters are both convenient and efficient and produce high patient satisfaction. However, e-visits are only conducted by a fraction of physicians in large part because these services are as well not typically reimbursed. Expanding Medicare coverage for telehealth is long past due.

Limitations of Part B Items and Services Defined as a Basic Telehealth Benefit

NCHC discourages CMS from adding limits and instead retain its proposed approach holding plans to existing requirements that benefits be clinically appropriate and provided in a manner consistent with professionally recognized standards of care.

Network Adequacy

CMS seeks comments concerning the impact expanded telehealth benefits will have on MA network adequacy policies. NCHC supports any effort to re-evaluate related policies in context of the increased MA telehealth utilization.

Currently, CMS uses quantitative adequacy standards such as minimum time or distance for enrollee travel. Presuming a significant use in expanded MA telehealth services, CMS should re-evaluate whether existing adequacy measurement formulas are appropriate.

Here, CMS should consider leveraging what the agency has proposed under Medicaid. That is, CMS would eliminate time and distance standards and instead establish minimum access standards for specified health care providers. While again MA already uses a set of qualitative standards to establish network adequacy, greater weight should be granted to measures that take into account improved access to care telehealth provides.

Per our mention of the VA use above, the use of telehealth can significantly increase access to care. As plans expand their use of telehealth services, MA network adequacy policies should reflect related improvements to access to care and in care quality.

Excluding Capital and Infrastructure Costs from Telehealth

The BBA excludes from additional telehealth benefits any capital and infrastructure costs and investments relating to such benefits. In the proposed CMS does not offer a definition of capital and infrastructure costs. CMS seeks comment on how to operationalize the exclusion of capital and infrastructure costs from the annual bid process.

Since there is no precedent for a benefit-related cost exclusion, it could prove to be initially difficult for plans to determine what costs should be excluded and how to operationalize the exclusion in the bidding process. NCHC is therefore concerned this lack of guidance may cause MA plans not to exploit expanding telehealth services.

More specifically, determining what portions of which costs should be excluded will be challenging because it is not clear from the statutory language what constitutes “capital” and “infrastructure” costs and because it will be difficult for plans to obtain related information from their contracted providers and vendors. There is no incentive for providers or vendors to accurately identify capital/infrastructure costs. In addition, plans would not have the ability to know whether reported costs were reasonably stated. This could lead to problems with plans actuarial attestations. Further, estimates of capital/infrastructure costs could vary appreciably between and among providers leading to inconsistencies in the amounts plans exclude from their bids. This in turn would lead to concerns about the fairness of the bidding process.

While there is an existing mechanism for excluding certain administrative/non-benefit expenses in plan bids, there is no comparable mechanism for excluding a portion of a medical expense. How would such an exclusion would be operationalized in the bid pricing tool? Additionally, it would be administratively burdensome for plans to recognize provider-specific exclusions in their claims capture and reporting.

CMS could stipulate a percentage of cost exclusion that represents the industry average of allowed fees as representative of the capital/infrastructure costs, rather than requiring plans to report actual capital/infrastructure costs. To operationalize the exclusion the fixed percentage could be excluded from the plan’s base period experience and trended forward.

We ask CMS to provide additional guidance on capital and infrastructure cost in the final rule to, again, prevent any unnecessary delay or disruption in expanding MA telehealth benefits.

We thank CMS for consideration of NCHC's comments. Should you have any questions please do not hesitate to contact NCHC's David Introcaso, Ph.D., Vice President of Policy, at 202.907.7426 or at dmintr@gmail.com.

Sincerely,



John Rother
President and CEO