



April 6, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

The Alliance for Connected Care (The Alliance) appreciates the opportunity to comment on the proposed rule and important provisions related to the delivery of telehealth and remote patient monitoring in the Medicare Advantage program. Our members strongly support your efforts to permanently expand access to telehealth in the Medicare Advantage program. We also deeply appreciate the many emergency measures taken to facilitate remote care during the COVID-19 public health emergency. We believe these changes will create an important opportunity to demonstrate the efficacy of telehealth and remote patient monitoring tools.

The Alliance is dedicated to improving access to care through the adoption of telemedicine and remote patient monitoring. The Alliance's membership brings together diverse industry leaders - from providers of direct patient engagement to physician consultation and remote monitoring, as well as the connected care technologies that are already facilitating the future of health care delivery. Members of the Alliance for Connected Care have seen firsthand how expanded access to telehealth and remote patient monitoring can better coordinate care, create economic efficiencies, and drive better health outcomes. Greater utilization of connected care technologies is a natural outcome of shifts to more outcome-focused and value-based care models. We applaud HHS for its push to support more value-based care models and support efforts to create more flexibility for care delivery within these models.

In light of the national emergency, we expect that many of these changes may be delayed or have already been altered through emergency regulations; however, we comment with the expectation that CMS will return to these priorities at a future date. With regard to telehealth provisions in particular, we strongly urge CMS to take into account its new experience with telehealth during the public health emergency when it returns to evaluate the questions posed in this regulation.

Within the Proposed Rule, we have identified four priorities for telehealth and connected care:

Medicare Advantage (MA) and Cost Plan Network Adequacy

The rule proposes to allow MA plans to receive a 10 percent credit towards the percentage of beneficiaries residing within published time and distance standards when they contract with telehealth providers in the following provider specialty types: dermatology, psychiatry, cardiology, otolaryngology and neurology.

The Alliance applauds CMS recognition of the capability of telehealth to meet network adequacy requirements as we believe current network adequacy requirements limit the utility of telehealth to address high-need services in health care shortage areas. We believe that the CMS could go further than 10 percent credit for time and distance standards, and could allow a wider range of provider specialty types.

Other leading voices have moved beyond network adequacy requirements, now that telehealth delivery models have matured. The National Association of Insurance Commissioners (NAIC) revised their model law on provider network criteria where they state that it may, at the discretion of the state insurance commissioner, include “other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care.”¹

As you know, Medicaid has also considered revisions to take telehealth into account for purposes of network adequacy through its 2018 proposed rule (CMS-2408-P) to overhaul the Medicaid managed care network adequacy criteria. In that rule, CMS proposes to do away with federal time and distance standards for measuring network adequacy by replacing them with more qualitative standards that more accurately reflect access and utility, noting that “a state that has a heavy reliance on telehealth in certain areas of the state may find that a provider to enrollee ratio is more useful than meaningful access, as the enrollee could be well beyond a normal time and distance standard but can still easily access many different providers on a virtual basis.” The agency goes on to cite a 2017 report by the USC-Brookings Schaeffer Initiative for Health Policy which notes that “in some clinical areas, telemedicine could make proximity measures obsolete, or counterproductive.”²

The Alliance believes that telehealth services can be used to fill in gaps in areas that are experiencing workforce and provider shortages in all markets, and amending the enrollee choice language would allow MA plans to better serve beneficiaries and expand access to high-value and effective treatments in medically underserved areas. In addition to the 10 percent credit for time and distance standards, we strongly encourage the addition of additional patient-focused and qualitative outcome measures.

¹ “MDL #74,” NAIC, Q4 2015. <https://www.naic.org/store/free/MDL-74.pdf>

² “Notice of Proposed Rulemaking (NPRM); Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care (CMS-2408-P),” CMS, 8 Nov 2018. <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24626.pdf>

We encourage CMS to move its assessment of network adequacy to more outcome-focused tools, such as beneficiary access, satisfaction, and wait times for providers – either in person or delivered via telehealth. We also encourage the use of qualitative tools to measure provider networks against the needs of enrolled populations and the clinical appropriateness of delivering that care remotely. With regard to provider types, we believe that current telehealth expansions taking place across many CMS programs will shortly demonstrate the capability of nephrology and a wide range of other specialties to be delivered remotely. We encourage CMS to take into account its experience with these expansions when finalizing this proposed rule.

Improvements to Care Management Requirements for Special Needs Plans (SNPs)

CMS proposes that that annual face-to-face encounters required for all SNPs under this new rule may include visual, real-time, interactive telehealth encounters. As noted in the April 2019 final rule, CMS believes MA additional telehealth benefits will increase access to patient-centered care by giving enrollees more control to determine when, where, and how they access benefits.

The Alliance for Connected Care strongly supports real-time interactive video as a means of care delivery and notes that the health community widely accepts the provision of real-time face-to-face video as equal to in-person care for establishing and maintaining clinician-patient relationships. As you know, the practice of medicine laws in all 50 states stipulate that a physician-to-patient relationship can be established virtually, so long as it's appropriate for the service to be delivered via telehealth. This position is strongly supported by the American Medical Association³ and the Federation of State Medical Boards, who assert that “physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.”⁴ An in-person requirement also limits access to the most vulnerable populations, who may have transportation, mobility or other barriers to accessing the healthcare system.

Additional Telehealth Benefits

Although CMS took the position that limiting MA Additional Telehealth Benefits (ATBs) to contracted providers will ensure additional oversight of providers' performance in their April 2019 final rule, CMS is now considering whether limiting MA ATBs to contracted providers may unnecessarily limit the ability of MA plans to furnish ATBs. CMS proposes that requiring non-contracted and contracted providers to meet the same ATB requirements will ensure ATBs are delivered in a manner consistent with the statute and plans will have necessary control over how and when services are furnished.

The Alliance for Connected Care strongly supports allowing all MA plan types, to offer ATBs through non-contracted providers and to treat them as basic benefits under MA. Alliance members believe that there should be little differentiation between telehealth and traditional healthcare services, and that CMS should move away from structures that treat telehealth differently from basic health benefits.

³ <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf>

⁴ https://www.fsmb.org/siteassets/advocacy/policies/fsmb_telemedicine_policy.pdf

Medical Loss Ratio (MLR)

CMS is proposing to amend the MA medical loss ratio (MLR) regulation so that the incurred claims portion of the MLR numerator includes all amounts that an MA organization pays (including under capitation contracts) for covered services. This proposal would include in the incurred claims portion of the MLR numerator amounts paid for covered services to individuals or entities that do not meet the definition of “provider.”

The Alliance supports this change. While most telehealth would fall under the provider definition – this provision may create additional flexibility and certainty, particularly for expanded supplemental benefits including remote care options that we believe are important to beneficiary health and wellness.

Thank you for your consideration, we look forward to working with you on this important effort. Please contact Chris Adamec at 202-640-5941 or cadamec@connectwithcare.org with any questions.

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac". The signature is written in a cursive, flowing style.

Krista Drobac
Executive Director
Alliance for Connected Care