



August 31, 2022

Submitted via regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information on the Medicare Advantage Program (CMS-4203-NC)

Dear Administrator Brooks-LaSure,

The [Alliance for Connected Care](#) (“the Alliance”) welcomes the opportunity to provide comments on the request for information on the Medicare Advantage (MA) program. The Alliance is dedicated to improving access to care through the reduction of policy, legal and regulatory barriers to the adoption of telemedicine. Our members are leading health care and technology organizations from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance works in partnership with an Advisory Board of more than 40 patient and provider groups, including primary care advocacy groups who wish to better utilize the opportunities created by telehealth.

The utilization of telehealth proliferated throughout the COVID-19 pandemic and has improved patient access to care, including within the MA program. In our comments, we outline the role that telehealth has played in providing access to care in the MA program and key policy considerations for CMS to ensure this care modality is available and effectively utilized within the MA program moving forward.

According to a recent [Alliance for Connected Care survey](#), telehealth is key to supporting and retaining the health care workforce. Practitioners reported that telehealth, and the ability to provide care from a range of locations when clinically appropriate, was a crucial tool to reduce challenges with provider burnout. The polling found 78 percent of health care practitioners agree that retaining the option to provide virtual care from a location convenient to the practitioner would “significantly reduce the challenges of stress, burnout, or fatigue” facing their profession. We applaud CMS for providing MA plans more flexibility in where providers can offer telehealth to beneficiaries, such as in their home, and encourage CMS to continue reducing any payment or practice barriers that impede access to care or greater flexibility for care that meets patient needs.

Our top recommendations for CMS include:

- Given the widespread experience with telehealth during the COVID-19 Public Health Emergency (PHE), we believe CMS may now move forward with dramatic expansions to the use of telehealth to meet network adequacy requirements.
- Clarify that the use of diagnoses obtained through audio-visual telehealth for risk adjustment purposes will continue after the end of the PHE.

- Promote additional paths to access practitioners across state lines by supporting licensure portability and ensuring that these providers count toward appropriate network adequacy requirements.

Statutory Limitations

In 2018, Congress passed the Bipartisan Budget Act of 2018 (P.L. 115-123), which greatly expanded coverage for telehealth services within the MA program. Specifically, Section 50323 of the law created new flexibilities that allowed MA plans to provide “additional telehealth benefits” to enrollees beginning in plan year 2020. CMS further solidified this change in the CY2020 MA and Part D Flexibility Final Rule ([CMS-4185-F](#)), which established regulatory requirements allowing MA plans to cover Part B benefits furnished through electronic exchange but not payable under section 1834(m) of the Social Security Act as MA additional telehealth benefits within the basic benefit structure.

This was a critical step to expand access to telehealth services and care options for MA beneficiaries. While these flexibilities have been paramount in ensuring MA enrollees could benefit from receiving telehealth services where and when they need it, more can be done to ensure that the MA program can reach its full potential on telehealth. In our comments, we outline the role that telehealth has played in providing access to care in the MA program and key policy considerations for CMS to ensure this care modality is available and effectively utilized within the MA program moving forward. For the potential of telehealth to fully come to fruition, additional action from Congress will be needed to authorize statutory changes under section 1834(m) and permanently allow more virtual care services and practitioners in Part B – therefore bringing more virtual care options into the base MA benefit. Such action will require the elimination of regulatory barriers currently in place within CMS programs that impede care delivery through telehealth, the implications of which are outlined below.

Expand Access: Coverage and Care

What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

In April 2019, CMS [finalized](#) policies under the CY2020 MA and Part D Flexibility Final Rule ([CMS-4185-F](#)) that allowed MA plans to offer additional telehealth benefits beyond what is required in Medicare fee-for-service. The Bipartisan Budget Act of 2018 granted authorities to CMS that allowed MA plans to offer additional telehealth benefits to beneficiaries in their bids for basic benefits beginning in plan year 2020, including the option for patients to receive health care services from their own home instead of traveling to a designated health care facility to obtain a virtual visit. Additionally, MA plans are able to offer supplemental telehealth benefits for services that do not meet the requirements for coverage under traditional Medicare. In 2022, about [95 percent](#) of MA plans offered and about 99 percent of beneficiaries had access to telehealth benefits.



At the start of the COVID-19 public health emergency, CMS [exercised](#) its enforcement discretion to allow MA plans to expand coverage of telehealth services beyond what was already approved by CMS as part of the plan’s benefit package. This includes allowing MA plans to use video-enabled telehealth visits to document diagnoses, waive or reduce enrollee cost-sharing for telehealth benefits, and provide enrollees access to Medicare Part B services via telehealth in any geographic area and from a variety of places.

As a result of these and other Medicare flexibilities, telehealth has been a critical tool to ensure Medicare beneficiaries could continue to access care throughout the COVID-19 pandemic. During the first year of the pandemic, [over 28 million](#) Medicare beneficiaries used telehealth, including almost half (49 percent) of MA enrollees. In fact, MA beneficiaries used more virtual care services than beneficiaries in traditional Medicare fee-for-service during this time frame, accounting for 35 percent of all telehealth services in MA compared to 25 percent in Medicare fee-for-service.

To ensure these critical services continue to be available to MA beneficiaries, especially those in underserved communities, once the public health emergency ends, we provide several recommendations below for how to improve access to telehealth in MA and eliminate regulatory barriers that impede care delivery through this modality.

Provide Clarity Around Risk Adjustment for Telehealth

In April 2020, CMS released a [FAQ document](#) outlining information and guidance related to risk adjustment for telehealth and telephone services in MA during the COVID-19 pandemic. CMS noted that “any service provided through telehealth that is reimbursable under applicable state law and otherwise meets applicable risk adjustment data submission standards may be submitted to issuers’ External Data Gathering Environment (EDGE) servers for purposes of the HHS-operated risk adjustment program.” CMS continued to allow MA plans to include video-based telehealth encounters when submitting diagnosis information for risk adjustment calculations throughout the pandemic. CMS also indicated that telehealth visits are considered equivalent to face-to-face interactions, and therefore meet the face-to-face requirement for risk adjustment when the telehealth service permits real-time interactive communication via interactive audio and video telecommunications technology.

Given the COVID-19 public health emergency is expected to end soon, we recommend that CMS provide guidance to clarify that the use of diagnoses obtained through audio-visual telehealth for risk adjustment purposes will continue after the end of the PHE to ensure that telehealth continues to be effectively leveraged and utilized in the MA program. This will help ensure that plans can submit the full scope of information on telehealth-obtained diagnoses that could impact payments and benefits to CMS. Providers and plans alike are looking for more certainty as we prepare for the end of the PHE, and updated guidance on what policies are expected to continue once the PHE ends would be beneficial for telehealth services to continue to be effectively leveraged and utilized. As a general principle, we believe that there is no



reason to treat telehealth visits differently from in-person visits and strongly encourage CMS to align requirements across both.

How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

The COVID-19 pandemic has further exacerbated existing mental and behavioral health care challenges. There has been a significant increase in anxiety and depression as well as rising drug overdose deaths, in addition to significant workforce shortages particularly for mental and behavioral health providers. Telehealth and digital health technologies can be used to facilitate greater integration of care. Telehealth has been leveraged throughout the pandemic to address provider workforce shortages and provide greater access to health care services, especially in regions and populations that lack access. Furthermore, telehealth technology supports greater integration within a health system. For example, provider-to-provider or e-consults can facilitate rapid exchange of information between a primary care provider and a specialist.

The United States currently faces unprecedented workforce challenges as a result of the COVID-19 pandemic. In particular, for rural and underserved communities, access to a health care provider is severely limited due to provider shortages. The patient-to-primary care physician [ratio](#) in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas. Provider shortages are associated with delayed health care usage, reduced continuity of care, higher health care costs, worse prognoses, less adherence to care plans, and increased travel. Telehealth can help address these workforce challenges by bridging access to health care providers for patients.

It is crucial that CMS leverage all tools to enhance access to these services after the PHE, and not take any steps that would reduce access to care, such as the inclusion of any in-person visit or care coordination requirements on mental health care. Such requirements effectively limit the reach of telehealth providers to treat only those patients they could also see in-person, thereby preventing telehealth from addressing workforce shortages and other barriers to access straining Medicare beneficiaries. CMS must support the maximum flexibility possible to help MA plans bridge workforce shortages and meet the behavioral health needs of their members.

What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

In the [Contract Year 2021 MA and Part D final rule](#), CMS [finalized](#) new policies that address maximum time and distance standards to strengthen network adequacy rules by encouraging the use of telehealth by providers in contracted networks. CMS provided MA plans a 10 percent credit towards the percentage of



beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers for certain specialties. The Alliance for Connected Care strongly supported these changes, as they begin to recognize the capabilities of telehealth to address unmet needs and provider shortages. The Alliance also strongly supported the expansion of provider types eligible for these services – as telehealth has been proven effective in a wide range of specialties.

During the COVID-19 pandemic, the United States demonstrated the capability of telehealth to meet a large proportion of all health needs. Given this experience, we believe it is now time for CMS to reevaluate how it can dramatically expand options for telehealth to meet network adequacy requirements – and it can do so responsibly by evaluating nationwide data on telehealth utilization, quality, and outcomes.

First, CMS should expand the list of provider types eligible for the 10 percent credit towards the percentage of beneficiaries residing within published time and distance standards to include all practitioners eligible to offer Medicare telehealth services. We see no reason that the list of providers eligible to contract for telehealth services with a MA plan would be any different from the providers eligible to offer Part B telehealth services.

Second, while we recognize that there are circumstances for which access to in-person care is required and therefore access to in-person services must be part of network adequacy, we broadly believe that telehealth should move beyond a 10-percent credit for time and distance standards and be treated more equally with in-person care. In particular, the Alliance believes that telehealth services can be used to fill in gaps in areas that are experiencing workforce and provider shortages to allow MA plans to better serve beneficiaries and support the expansion of MA plan options in medically underserved areas. The most obvious use case for this flexibility would be the expansion of services in rural areas with provider shortages – as you know, MA plans have long been less prevalent in rural areas than non-rural areas, with approximately 30 percent participation.¹

Finally, CMS should consider moving MA beyond time and distance standards for network adequacy entirely. While the adequacy of networks are of course important, geographic distance and patient access are not the same thing. As health care delivery models leveraging both telehealth and in-home care expand, we encourage CMS to reconsider the merits of using time and distance as metrics entirely.

Other leading voices have moved beyond time and distance 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.”²

¹ County-level Medicare / MA Enrollment Data Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract>

² “MDL #74,” NAIC, Q4 2015. <https://www.naic.org/store/free/MDL-74.pdf>

As you know, Medicaid has also considered modernizations 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 went 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.”³

We encourage CMS to modernize its assessment of network adequacy to emphasize more outcome-focused tools, such as beneficiary access, satisfaction, and wait times for providers – either in person or delivered via telehealth. These tools would better capture the value of telehealth services to patients in MA plans. 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.

Advance Health Equity

What steps should CMS take to better ensure that all MA enrollees receive the care they need, including enrollees who live in rural or other underserved communities?

Close the Digital Divide by Addressing Barriers to Broadband Access and Affordability

The Alliance believes that telehealth has the potential to broaden access to care and improve patient engagement, and as such demands thoughtful consideration to ensure all Americans are provided equal and equitable access. Telehealth has effectively addressed longstanding equity issues related to health care during the pandemic – including by filling gaps in care delivery to ensure patients can access care when and where they need it, expanding access to more culturally competent care options, and reducing logistical burdens such as transportation barriers or lack of time off work. While telehealth has been critical to ensuring access to care throughout the pandemic, particularly in rural and underserved areas, there are still barriers that need to be addressed to close the digital divide.

As highlighted by the COVID-19 pandemic, access and affordability of broadband is an important aspect to accessing health care services, and is essential to expanding access to telehealth services. Without it, we will never reach populations who need access to behavioral health, primary care, specialty consults and more. We must invest in broadband alongside changing coverage policy for telehealth.

³ “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>



The inequities in broadband access across geography, race, and income are clear. According to a 2021 [Pew Research Center survey](#), home broadband use varies significantly across demographic groups, including income levels and race. Nearly all Americans with annual household incomes above \$75,000 reported having a broadband connection at home, compared to just half of households making less than \$30,000 a year. Similar stark contrasts can be seen between races and geography, with 80 percent of White people having access, compared to just 70 percent and 65 percent of Black and Hispanic people, respectively. Additionally, more than 35 million rural Americans lack access to broadband.

In January 2021, the Federal Communications Commission (FCC) released their fourteenth annual [Broadband Deployment Report](#) finding progress in closing the digital divide. The gap between urban and rural Americans with access to high-speed broadband service has been nearly halved, falling from 30 percentage points at the end of 2016 to just 16 points at the end of 2019. Despite significant progress, tens of millions of Americans do not have access to broadband. Estimates range from roughly 14.5 million to 42 million Americans in total, with the lowest coverage levels experienced in Tribal and rural areas.

CMS should coordinate with other federal agencies to continue and enhance ongoing efforts to ensure equitable broadband infrastructure. We recognize that progress has been made and major efforts are underway in closing broadband gaps, yet the challenges remain for many. We recommend CMS work with the HHS Secretary and the FCC to redouble efforts to ensure the technology for virtual care is available through federal programs that help to improve broadband connectivity. This includes maintaining access to audio-only services for the many Americans who continue to lack broadband access to ensure beneficiaries can continue to access care through this modality.

Expanding Practitioners Able to Provide Care

We urge CMS to address Medicare provider enrollment concerns that we believe will actively undermine the ability for telehealth to strengthen the health care workforce in both Fee-For-Service and potentially for Medicare Advantage. During the COVID-19 PHE, CMS allowed practitioners to render telehealth services from their home without updating their practice location for purposes of Medicare enrollment. Unfortunately, this policy is set to expire at the conclusion of the PHE – meaning many telehealth providers will be required to report their home address as their practice location. We are concerned that the requirement to publicly report, and have CMS publicly disclose a home address, creates huge privacy and safety concerns for these clinicians. The Alliance respectfully requests that CMS provide additional guidance to providers who wish to continue providing services from their home but do not feel comfortable listing their home address.

Access to Care Across State Lines

One barrier to MA plans further expanding access to care virtually are state licensure rules that have limited providers' ability to give care across state lines. State lines create artificial barriers to the delivery of care – complicating access for patients and creating additional burden on clinicians. These lines sometimes split major urban areas and hamper the ability of telemedicine providers to fill in gaps in the care delivery system and provide high value care directly to consumers in rural or underserved areas.



While we recognize that health plan structures operate on a state basis, the providers providing care for beneficiaries of these plans often do not. CMS must work to strengthen the ability of health care providers to meet needs in all areas, including underserved areas, by strengthening access to providers across state borders.

According to a study published in [Health Affairs](#), approximately two-thirds of out-of-state Medicare telehealth encounters by rural patients were with a clinician in a bordering state. Current efforts to expand interstate licensure have been insufficient to meet the needs of patients and the clinicians seeking to better serve them. Health care professionals are prohibited from treating patients in states where they are not licensed, and state-by-state licensing processes are burdensome and expensive.

COVID-19 [exposed](#) a huge opportunity to strengthen access to care and emphasized how that care has been hampered by the fragmentation of state practice act laws and regulations. The ability for licensed, credentialed health care professionals to provide patient care across state lines via telehealth during the pandemic helped maintain continuity of care, promoted patient choice, helped address workforce shortages, and improved access and care coordination. As licensure and telehealth flexibilities began to [expire](#), providers have had to cease expanded care or pursue cumbersome and expensive state-by-state licensing requirements to help patients in other states. Without permanent policy measures to adjust to these changes, patients have to either travel long distances to see a provider in person or cancel appointments, which creates a barrier to accessing convenient care.

We recommend that CMS promote additional paths to access practitioners across state lines by supporting licensure portability and ensuring that these providers count toward appropriate network adequacy requirements. CMS should convene experts and begin working toward the development of a voluntary, national framework for interstate licensure using a policy of mutual recognition that states would voluntarily adopt. Such a framework would allow patients to receive care beyond their state borders, and allow qualified health care providers already licensed in a U.S. state or territory to treat patients without the costly and time-consuming burden associated with purchasing and renewing multiple state licenses. Additional information on this national framework (modeled on the [Driver License Compact](#)) can be found [here](#).

Thank you for the opportunity to comment on this important topic – we hope you will consider these recommendations as you look to improve access to telehealth services within the MA program. We look forward to working with you and welcome further discussion on this topic. Please reach out to Chris Adamec at cadamec@connectwithcare.org with any questions.

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac".

Krista Drobac
Executive Director, Alliance for Connected Care