BETTER MEDICARE ALLIANCE

1411 K Street NW, Suite 1400
Washington, DC 20005
202.735.0037

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

June 2, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: Suggested Guardrails for Audio-Only Telehealth Visits for Risk Adjustment Purposes

Dear Administrator Verma:

Better Medicare Alliance, on behalf of our 143 Ally organizations and 460,000 beneficiary advocates, is committed to ensuring stability and continuity for the 24.4 million Medicare Advantage beneficiaries. We commend the Centers of Medicare & Medicaid Services (CMS) for the addition of telehealth services during the current public health emergency and the inclusion of diagnoses obtained during these visits for the purposes of risk adjustment.

Better Medicare Alliance (BMA) is writing in response to our recent conversations regarding audio-only telehealth visits for Medicare Advantage risk adjustment purposes. We appreciate CMS sharing their perspectives with us and other stakeholders. We join with many of those stakeholders in urging CMS to permit diagnoses obtained during audio-only telehealth visits to count towards a beneficiary's risk score and to do so in a way that is workable for health plans, providers, and beneficiaries. We ask that this decision be made as soon as possible to ensure that data collected in 2020 is as complete and accurate as possible amid the COVID-19 emergency. We believe that the ten guardrails CMS proposed in their entirety are unworkable, place an undue burden on health plans and clinicians, and detract from the focus on providing high-quality, accessible care during this period of social isolation. This is particularly important as we seek to protect older adults and disabled beneficiaries who are an especially vulnerable population now, and in the months ahead.

The public health emergency and stay at home orders have led to a nationwide delay of in-person clinical care and elective services. While providers and health plans are working together to provide needed care and reduce the impact of this pandemic on Medicare's vulnerable population, utilization of care and services remains low. The use of telehealth visits has contributed meaningfully to allowing providers and plans to reach out to beneficiaries and replace in-person visits with telehealth visits—ensuring that those with new medical concerns and those with ongoing chronic conditions are able to interact with their providers to manage their health.

Medicare Advantage is unique in requiring accurate assessment of each beneficiary every year to determine their health conditions and ensure that risk adjusted payments reflect a beneficiary's current diagnoses and conditions. It is extremely important to make use of the tools available to obtain this data. CMS has already taken action to permit data obtained during audio-video telehealth visits to provide diagnoses for risk assessment, and we continue to urge CMS to

equally permit the same for audio-only telehealth visit. As this letter will describe, there are numerous reasons to support this allowance, most prominently because beneficiaries do not have equal abilities or technology to access telehealth visits and providers are using video and audio-only telehealth visits interchangeably. The distinction for risk assessment purposes inhibits the ability of providers to utilize these patient visits to obtain data required under Medicare Advantage. Omitting the use of the data obtained during audio-only telehealth visits unreasonably limits the use of available, timely and clinically accurate data on these patients that could be used to provide the required information on millions of Medicare beneficiaries.

The reality is that many beneficiaries are not able to make in-person visits as they are concerned about exposure to COVID-19, nor should they be expected to, and many have limitations that inhibit the use of video telehealth visits. Even those who are willing to use telehealth, often chose audio-only rather than video telehealth visits. The reasons vary, but the fact is not all beneficiaries have access to the necessary technology and many prefer to use their telephone to communicate with their health providers.

A recent survey of more than 2,000 seniors on Medicare Advantage conducted by *Morning Consult* for BMA found that, while those who use telehealth services report high satisfaction, only 24 percent of beneficiaries have accessed this technology during the COVID-19 pandemic. Nearly one-third of beneficiaries say they are uncomfortable using telehealth.[1] Allowing audio-only telehealth visits – whereby seniors could connect with their health care provider through a simple phone call – has and continues to be a critical way to protect older and vulnerable seniors' access to care during this unprecedented time.

A 2019 Amwell study found approximately half of people over age 65 surveyed were willing to try telehealth.[2] However, many beneficiaries are unable to utilize this technology due to the lack of broadband access. According to the FCC's 2018 Broadband Deployment Report, 24 million Americans did not have access to broadband at the benchmark speed of 25 Mbps/3Mbps. Additionally, the same report found that rural areas lag behind urban areas in the deployment of mobile broadband and fixed broadband with 68.6% of people in rural areas having access to both compared to 97.9% in urban areas.[3] Limited access to audio-video technology required for risk adjustment purposes hinders the ability to assess and document the current health status and chronic condition verification, as required in Medicare Advantage.

Access problems are not limited to the internet or devices, as some beneficiaries with functional or cognitive impairments are unable to utilize audio-video technology. These beneficiaries prefer audio-only over audio-video visits. Others may be limited by financial constraints that prevent them from purchasing the needed devices and internet services. Health providers are reporting that the percentage usage of audio-only telehealth visits is vastly higher than that of audio-video telehealth visits. Security Health Plan reported 75 percent of their telehealth visits as

1 *Morning Consult* survey of 1,020 seniors on Medicare Advantage. Conducted May 16-18, 2020.
2 https://www.americanwell.com/resources/telehealth-index-2019-senior-consumer-survey/
3 https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-report

audio-only, and Kaiser Permanente reported 85 percent of their telehealth visits were audio-only, these are just two examples of widely reported experience from providers across the country.

While BMA appreciates that CMS has provided Medicare Advantage plans the opportunity to provide audio-video devices to beneficiaries, this does not solve the problem of not having access to broadband internet, beneficiary preference of audio-only, or beneficiary functional or financial limitations.

The public health emergency coupled with the vulnerabilities of the Medicare Advantage population has led to the recognition by many, including CMS, of the need to eliminate obstacles and burdens for beneficiaries in accessing clinically appropriate care. Given the decline in elective procedures and out-patient visits, which may well continue in the months ahead, there will be limited opportunities for providers to make up these visits using telehealth. Requiring telehealth visits to have both audio and video components puts additional constraints on the assessment and documentation of current health status.

Furthermore, CMS has permitted audio-only flexibilities when low health care utilization exists in several areas. In Traditional Fee-for-Service (FFS) Medicare, providers are currently permitted to have audio-only telehealth visits with patients that is documented in the medical records system and the claim submitted for payment. In the Stars Rating system, CMS has recognized that during this public health emergency there is systemic data quality issues and has permitted the substitution of 2020 data for 2021 Star Ratings. Finally, to accommodate access issues for beneficiaries in opioid treatment programs, CMS has permitted these programs to furnish services using audio-only technology provided all other programmatic requirements are met. These same leniencies should be granted for risk adjustment purposes.

CMS expressed concerns regarding program integrity issues and the alleged possibility of large increases in risk scores if diagnoses obtained through audio-only telehealth visits are permitted for 2019-2020 plan year as with audio-visual visits. Experience and research demonstrate otherwise. Research has shown that there are not large fluctuations in risk scores year over year. A 2018 Avalere study looked at changes in the HCC model for 2019 and found that risk scores only increased by 0.78 percent, with 79 percent of health plans having an increase in mean risk score ranging from 0.005 to 0.023.[4] It can be deduced that there will not be large fluctuations in risk scores between 2019, 2020, and 2021 provided the same amount of data is available.

Additionally, a 2015 study found that telehealth visits produced similar outcomes as face-to-face appointments. Permitting diagnoses obtained via audio-only telehealth visits did not result in a spike of beneficiary risk scores. Diagnosis and treatment in this care setting was equal to that of face-to-face visits.[5] For all these reasons, there is little expectation that there will be a wide variation, nor increase in invalid risk scores. Audits already in place are available to identify and

[4] https://www.avalere.com/insights/impct-of-cms-changes-to-the-medicare-advantage-risk-asjustment-models
[5] Flodgren G, Rachas A, Farmer AJ, Inzitari M, Sheppard S. Interactive telemedicine: effects of professional practice and health care outcomes. Cochrane Database of Systematic Reviews 2015, Issue 9. Art. No.: CD002098. DOI: 10.1002/14651858. CD002098.pub2

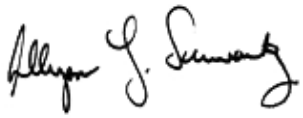
remedy misuse; therefore, additional audits that are administratively burdensome and costly are unnecessary.

Finally, in order to provide needed care to those individuals who cannot utilize or access audio-video technology, audio-only telehealth has proven to be an extremely valuable tool to ensure ongoing care is available during this unprecedented national health emergency. There is strong reasoning to accept diagnoses obtained through these patient-clinician encounters for risk adjustment, as they are recognized as clinical encounters in every other sense.

In addition to the points set forth in this letter and the referenced studies, please find our feedback on the specific guardrails CMS suggested a few weeks ago as conditions to allow the use of clinical assessments obtained during audio-only telehealth visits. We appreciation your consideration of this feedback and welcome further dialogue that will lead to CMS lifting the restrictions on audio-only telehealth visits.

Thank you again for all your work during this public health crisis. We look forward to your response.

Sincerely,



Allyson Y. Schwartz
President & CEO, Better Medicare Alliance

cc: **Demetrios Kouzoukas**, Principal Deputy Administrator of the Center for Medicare & Medicaid Services;
Cheri Rice, Deputy Director, Parts C and D, of the Center for Medicare & Medicaid Services

BETTER MEDICARE ALLIANCE

1411 K Street NW, Suite 1400
Washington, DC 20005
202.735.0037

BetterMedicareAlliance.org
/BetterMedicareAlliance
@BMAlliance

Better Medicare Alliance Feedback on
CMS Suggested Guardrails for Audio-Only Telehealth Visits for Risk Adjustment

CMS Suggested Guardrails:

1. Restrict diagnoses for risk adjustment purposes from audio only visits to established patients.

We view this suggested guardrail as unnecessary and, at best, too limiting. Given the rationale articulated in the letter above, the importance of accurate data for risk assessment, and the unprecedented current circumstances due to COVID-19, CMS should make further allowances to ensure accurate and adequate data collection on beneficiaries' health status.

Should CMS move forward with this guardrail we recommend CMS define "established patient" so that diagnoses from audio-only telehealth visits would be counted for any patient who has received any professional service from the physician or physician group practice (same physician specialty) within the previous three years.

This definition would be consistent with the one in the Medicare Claims Processing Manual (Chapter 12, Section 30.6.7), in which CMS defines a "new patient" as "a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years."

2. Limit diagnoses from phone encounters to pre-existing conditions from prior encounters that have been submitted for risk adjustment purposes.

We recommend that this suggested guardrail be removed, and new conditions be counted for risk adjustment. CMS should not limit diagnoses from audio-only encounters to only those related to pre-existing conditions from prior encounters. CMS does not limit diagnoses from office/outpatient visit services to pre-existing conditions from prior encounters even when such services are performed via telehealth. Audio-only telehealth visits should be treated consistent with diagnosis codes obtained from office/outpatient visits under Traditional FFS Medicare.

3. Restrict diagnoses from phone only to those that result from six evaluation and management codes paid for by Traditional FFS Medicare for phone visits.

We disagree with this suggested guardrail. We agree that diagnoses that result from telephone evaluation and management services should be included in risk adjustment, and that diagnosis codes from audio-only visits should be treated consistently with how they are treated for the same service when delivered face-to-face or via video-enabled telehealth. CMS should include diagnoses from audio-only telehealth visits that CMS has already indicated meets the telehealth requirements and are eligible for an existing Medicare risk adjustment.

4. Limit audio-only diagnoses for risk adjustment purposes to those phone visits initiated by the patient, such that the phone encounter is not prompted by the plan or physicians, unless it is followed up with a lab result.

We disagree with this suggested guardrail, as written that the contact must be initiated by the beneficiary as this is inconsistent with the way patient care is conducted. Appointment scheduling and patient outreach is frequently initiated by the provider and appropriately so. However, we agree that the patient should be able to elect their preferred communication option, which should include telephone or audio-only option. Patients should be given all their options for communication and be able to choose the best way to communicate for themselves.

5. Restrict diagnoses to those captured by two or more providers not within the same practice.

We recommend that this suggested guardrail be removed. Many patients see only one provider practice to manage their chronic conditions. This guardrail would put undue burden, in time, convenience, and cost on patients having to see multiple providers for the sole purpose of risk adjustment. In addition, by requiring additional, unnecessary clinical visits, this proposal is inconsistent with appropriate clinical practice.

6. Diagnoses captured from phone visits would count only if tied to a specific list of lab tests.

We recommend that this suggested guardrail be removed. Lab tests are not the only way to confirm a diagnosis. Conditions may be supported by other diagnostic tests or pharmacy claims. In addition, some diagnoses may have none of the above, for example, depression, morbid obesity, quadriplegia, and pressure ulcers are not determined from a lab test and/or by diagnostics. CMS does not limit diagnoses from office/outpatient visits services to those that may be tied to a specific list of lab tests Further, CMS does not permit the use of labs or diagnostics in a RADV audit to confirm an HCC/diagnosis, so this proposal is counter to previous CMS guidance Diagnosis codes from audio-only visits should be treated consistent with how diagnosis codes from office/outpatient visits are treated.

7. Diagnosis captured from phone visit would have to be supported by additional documentation in the medical record beyond what is required today.

We recommend that this suggested guardrail be removed. We agree that documentation is important but, are concerned about placing undue burdens on physicians during this time of health crisis. CMS is aware of providers' difficulty in providing thorough documentation during this epidemic and has relaxed standards. In addition, this guardrail runs counter to one of the Administration's top priorities to reduce provider administrative burden. Just one example is CMS having reduced documentation requirements in the last two physician payment updates in 2019 and 2020 in order to decrease the burden on providers. This proposal is inconsistent with CMS' announced actions while placing additional burdens on health plans to find ways to obtain this added documentation.

8. Plans would be required to self-audit using CMS-approved independent auditors, reviewing 100% of phone only encounters and reporting back to CMS.

We recommend that this suggested guardrail be removed. See #9 for additional detail.

9. A plan attestation would confirm that phone submissions are 100% accurate and meet CMS criteria.

We recommend that CMS remove both #8 and #9 suggested guardrails. A 100% audit is a very high bar and creates administrative burden for health plans, physicians, and hospitals. Records from providers and facilities would have to be obtained and provided to independent auditors, adding unnecessary administrative burden and cost. Adding such a burden as attention should be focused on care delivery is unreasonable. In addition, accuracy rates should be aligned with Traditional FFS Medicare and should not be more punitive than they are currently.

10. Cap at the plan level on how much diagnoses can increase plans' average risk scores from last year.

We recommend that CMS remove this suggested guardrail. While a cap would appear to be a simple way to control increases, they can also discourage accurate risk assessment and limit care to patients as health plans approach the cap. Risk adjustment that is stable and accurate is critical to providing innovative, effective, and high-quality care to Medicare beneficiaries and should be protected.

Comments on Additional Suggestions made to stakeholders during the meetings on audio-only telehealth visits:

1. Delay in submission of 2020 encounter data until December 31, 2020.

We agree with this recommendation as a reasonable accommodation given the national health emergency.

2. Year-round open enrollment.

We ask that discussion of such a change be delayed. There is already significant uncertainty for contract year 2021 and 2022, due to the impact of COVID-19 and the disruption it has caused to health care, including; ongoing COVID cases with particular risk for older adults, low or high utilization in 2020 and 2022, disruption to the Star Rating system, lack of data for risk adjustment, and impact on 2022 benchmarks ---all issues that require attention to ensure stability for Medicare Advantage. We would look forward to discussion of potential changes to enrollment that would ease the process for beneficiaries but believe that this is not the appropriate time for immediate implementation of this suggested change.