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Meena Seshamani, MD PhD
Deputy Administrator and Director, Center on Medicare
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Medicare Advantage Request for Information (RFI)

Dear Dr. Seshamani:

Included Health appreciates the opportunity to submit the following response to the Medicare Advantage (MA) RFI. At Included Health, we are removing the friction from unpleasant patient experiences in order to provide high quality care for patients and family caregivers across the country. We are not just setting the standard in healthcare, but raising it, for everyone. Included Health provides unique virtual care services that uses innovative and emerging technology, including telehealth and artificial intelligence (AI), to better serve patients across the lifecycle nationwide. By leveraging the combination of high-quality care delivery via telehealth, and data-powered engagement which enables patient advocacy and navigation to local community providers and resources, Included Health is creating the future of healthcare. A Medicare Advantage beneficiary using Included Health gets the unique benefit of care continuity with easy follow-ups with the same providers they have previously seen, and access to integrated labs, their EHRs, and a referral network of local specialists that they can choose to see in-person.

While the rest of the healthcare world seems to be moving towards creating more fragmentation and silos or attempting to cut costs by taking services away, at Included Health we believe that data, technology and clinical expertise when effectively combined can drive better outcomes. We are the first nationwide virtual care practice to enroll and serve Medicare Part B beneficiaries, and are also providing affordable visits to active and retired TRICARE beneficiaries and their families, Medicare Advantage, Medicaid and working families in other states. Because of this we have been able to serve a vital public health role in mitigating the case of infectious disease spread and providing safe access to routine care to all who need it.

With this in mind we have outlined thoughtful recommendations to ensure effective, ongoing quality care delivery and also ensure program and fiscal integrity for the Medicare program.

Advance Health Equity
Improving Access to Culturally Concordant Patient Navigation

Although the uninsured rate in the US is at an all-time low of eight percent, navigating the health care system is still very complicated for many, and the average person does have the knowledge or expertise to maneuver through our health care system effectively. The White House agrees as

noted in the 2022 Unity Agenda and Strategy, "Finding the right care or an available provider can be a frustrating experience. We need to make it easier for Americans both to find help, and to receive it." We recommend that CMS include patient navigation services like advocacy, financial guidance, claims support, care management, benefits routing and provider matching as core component of Medicare Advantage and Medicaid managed care models to help people find high quality in-network providers

Our MA plan partners currently use MA rebate dollars to advance health equity and address SDOH by contracting with us to offer Included Health Communities services. We understand the importance of addressing health inequities by providing affirming care from our diverse and inclusive health care practice and community health workers. Included Health Communities, which will house Included Health's LGBTQ+ care equity program, our Black community focused service (currently being developed as part of our Black Community Innovation Coalition), and other future services developed for under-resourced communities.

These services enable tailored and culturally concordant care coordination and patient advocacy for those that identify with the respective community and their family allies. This crucial component of our comprehensive care model requires a screening of SDOH needs, and provides information to patients to help them navigate the complex and sometimes traumatizing world of health care. Our team of trained community health workers connects beneficiaries with affirming and best quality in-network health care providers in their local community who have attested to providing culturally and gender affirming care and meets their unique clinical needs. This comprehensive and tech-enabled support includes services like advocacy, financial guidance, claims support, care management, benefits routing and provider matching to help people find high quality in network providers.

We believe that a provider being well informed by the knowledge of a community means a provider has cultural knowledge, disease knowledge and historical knowledge of that community. Cultural knowledge includes understanding people's lifestyles, identities and common language and experiences in the community. Disease knowledge means understanding conditions or disease risks that are specific to or more prevalent in that community. Historical knowledge means understanding the history of traumas and injustices, medical and non-medical, that the community has faced and continues to face. While these three competencies are critical, active and engaged listening is foundational to a provider being an effective partner to the specific community as providers need to understand their patients as individuals.

When people exhaust their ability to armor up and engage with healthcare, they may postpone or avoid care. People may postpone care to take more time to prepare before their next appointment or to recover from a negative experience. People may avoid care due to costs or to protect against having repeated traumatic interactions with the healthcare system. People seem to completely avoid care when they can no longer find a way to get what they need from healthcare, or when they believe their interactions are causing more harm than good.

To address these pervasive challenges experienced by our patients broadly, Included Health also uses artificial intelligence and data-powered engagement to improve care coordination and care management. These features provide information to patients to help them navigate the complex world of health care, and also connects a patient with the best quality doctor or specialist in their local community that meets their unique medical. Patients and their families can make informed decisions about their healthcare treatment strategy at the onset of their diagnosis which allows them to pick the most effective treatment plan for their needs. This comprehensive and tech-enabled support includes services like advocacy, financial guidance, claims support, care management, benefits routing and provider matching to help people find high quality in network providers.

Quality Improvement Program
CMS should require all MA plans to address health and health care disparities as a topic area of their quality improvement strategy (QIS) in addition to at least one other topic area. MA plans should also be given the discretion to define their own performance targets and metrics of success within their respective QIS programs related to health care disparities.

Expand Access: Coverage & Care
Access to Behavioral Health

We acknowledge that the multi-demics of the past two years have drastically impacted the demand for mental health support affecting our patients as well as front-line workers including our clinicians. More than one third of Americans live in a community that lacks a mental health provider according to the Health Resources and Services Administration, and the number of providers available in those areas will only meet about 27 percent of the demand for mental health.[1] Research shows that mental health needs have been particularly impacted with half of health workers reporting burn out, and four in 10 adults reporting symptoms of anxiety or depression during the pandemic in contrast to only one in 10 during the previous year.[2] Furthermore, 36 percent of adults reported difficulty sleeping, 32 percent reported poor appetite or overeating, 18 percent reported difficulty controlling their temper, 12 percent reported increased alcohol or substance use, and 12 percent reported worsening chronic health conditions—all due to stress and worry over the pandemic. The pandemic has drastically impacted the demand for mental health support, and there is an increasing number of caregivers reported experiencing anxiety and burnout over the past year. As America's mental health continues to deteriorate, there are simply not enough mental health professionals to address increasing behavioral health needs. As the country recovers and rebuilds from the pandemic, it is critical that we make behavioral health care services more available and accessible, and that we

[1] USAFacts, *Over one-third of Americans live in areas lacking mental health professionals* (updated July 14, 2021),available here.

[2] The Kaiser Family Foundation, *The Implications of COVID-19 for Mental Health and Substance Use* (Feb. 10,2021), available here.

make the advances in behavioral telehealth care delivery a permanent part of our health care system.

The demand for mental and behavioral health services across patient populations is likely to continue after the coronavirus public health emergency (PHE) ends, further underscoring the ongoing need to eliminate barriers and ensure access to these vital services. With this in mind we have outlined thoughtful recommendations to sustain and improve patient access for affordable and quality behavioral health services.

Included Health's care model truly integrates behavioral health with primary care in a way that has not been optimally achieved in brick-and-mortar health care. Each of our primary care providers are trained in conducting behavioral health screenings and can identify behavioral health needs of patients that originally present for a physical ailment. Those providers can provide some level of behavioral health service and also seamlessly connect patients to a trusted behavioral health professional for ongoing treatment or therapy e.g. psychiatrist, psychologist, LCSW, counselor.

Our impact is evident showing telehealth's effectiveness in reducing depression symptoms. Our practice uses PHQ9 which is the professionally known standard and scale for measuring the presence and severity of depression. When we reviewed data for 2300 patients for those receiving four psychiatry visits, over 60 percent of patients improved PHQ9; for those receiving eight therapy visits 44 percent of patients improved the PHQ9 metric.[3]

To complement our primary care practice Included Health also uses a care team, artificial intelligence and data-powered engagement that offers a more tailored care experience. These components of our comprehensive care model require a screening of SDOH needs, and provides information to patients to help them navigate the complex and sometimes traumatizing world of health care. Our care model will also connect patients with an affirming and best quality doctor or specialist in their local community that meets their unique clinical needs. Patients and their families can make informed decisions about their healthcare treatment strategy at the onset of their diagnosis which allows them to pick the most effective treatment plan for their needs. This comprehensive and tech-enabled support includes services like advocacy, financial guidance, claims support, care management, benefits routing and provider matching to help people find high quality in network providers.

Improving Network Adequacy

Medicare premiums are rising, and beneficiaries are expected to save between three and eight percent more to cover premiums, deductibles, and other health expenses over the next five years. Research shows that Medicare beneficiaries are more likely to skip or delay needed care because of costs than older adults in other high-income countries. Medicare beneficiaries should not have to make unconscionable decisions about how to use their discretionary dollars. Generally,

[3] Case Study: Reducing Depression Symptoms with Virtual Care. Doctor On Demand. 2020.

high out-of-pocket health costs can lead patients to delay care or forgo it entirely, which can produce poorer health outcomes and raise overall health care spending.

Moreover, the uncertainty of navigating a post-pandemic future is also taking a toll on the health care provider workforce. This country faces an unabating pandemic and growing shortage of primary care and behavioral health providers that continues to pose financial strain on health care providers and patients. Research shows that half of health workers are reporting burn out, and provider shortages are impacting patient access. Excluding telehealth providers from any network, benefit, or service makes the limited number of provider resources presently available even more limited. This disproportionately affects those who already experience the harsh reality of finding a healthcare provider who accepts new patients and waiting weeks for the first visit.

Contrary to popular belief, virtual health care providers and traditional brick-and-mortar providers are not competing with each other for patients. More often than not, as evidenced by our telehealth and navigation model, they work collaboratively to ensure optimal care coordination and care management when needed which reduces fragmentation, duplication of services and delays in receiving necessary care. Also similar to a traditional health care experience, telehealth enhances the longitudinal patient-provider relationship.

We recommend that CMS continue modernizing their network adequacy quantitative criteria with respect to telehealth to maximize the ability for MA plans to improve access to providers in their networks. Access to care is not just a rural issue. In urban areas older adults struggle to make it to visits and others are hindered by traffic delays. In 2020, CMS modernized MA network adequacy access standards to include telehealth for specialties such as primary care and psychiatry. However, CMS still models its qualitative access standards based on outdated access criteria such as time and distance while other federal programs such as TRICARE, have significantly updated their access standards to meet the needs of patients. For example, TRICARE uses wait times and travel times as access standards. Additionally, the Veterans Administration, through its *Anywhere to Anywhere* initiative, recently issued a rule that would significantly reduce barriers to telemedicine for purposes of ensuring providers are available throughout the country.[4]

CMS proposed to require QHPs to report data in 2023 on whether network providers offer telehealth services and sought comment on whether and how telehealth availability might be incorporated into network adequacy standards. The plan did propose a favorable network adequacy standard in the form of appointment wait times. More specifically, CMS has set a maximum appointment wait-time for which appointments must be made available including primary care (15 days), behavioral health (10 days), and non-urgent specialty care (30 days). Plans would attest that 90% of contracted providers meet the wait-time standard.

[4] Department of Veterans Affairs. Authority of Healthcare Providers to Practice Telehealth (38 CFR 17).

In November 2018, CMS encouraged states to use other measures in addition to time and distance for their Medicaid programs.[5] This rule, as well as a White House Report, highlighted a 2017 Brookings/Schaefer Center report which indicated that in some clinical areas, telemedicine could make proximity measures obsolete, or counterproductive. And as of 2015 the National Association of Insurance Commissioners (NAIC) recognized telehealth as part of the provider network for the commercial market in a revised model law.[6] The NAIC said that provider network criteria may include "other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care."

We recommend that CMS allow MA health plans to contract with video-based telehealth providers that meet a minimum wait time of three days, in lieu of maximum time and distance standards, to count toward the minimum number of required providers. The average wait time to see a primary care provider in the U.S. is 4 weeks.[7] Additionally, we recommend that CMS allow MA health plans more flexibility to propose innovative models based on benefit design that count video-based providers toward the minimum number of providers in large metro and metro counties as well as CEAC, rural, or micro counties such as 1) contracting with providers that meet a minimum wait time; 2) hours of operation; or 3) accepting new patients. Video-based tools should be an integral component when determining network standards because health professionals using video-based tools are capable of providing more comparable service delivery to traditional face-to-face than service delivery that relies solely on an online questionnaire, telephone, and text message.

Now that telehealth is no longer a supplemental benefit, MA plans would not be replacing a basic benefit with a supplemental benefit. Patients would still have a choice between seeing a provider in person or by telehealth. Congress' requirement that MA plans give members an in-person option for care does not prevent CMS from allowing MA plans to at least *partially* meet network-adequacy standards by contracting with telehealth providers (i.e., providers available face-to-face via video on a routine and follow-up basis). For example, if the network adequacy standards require an MA plan to provide access to ten psychiatrists in its network for a particular geographic area, CMS should permit the MA plan to contract with tele-psychiatrists for at least a s*ubset* of those ten. This type of change would substantially increase access to needed care for MA plan members, especially within healthcare provider shortage areas and within communities in dire need of mental health services due to the national opioid addiction crisis.

Mental health and substance abuse treatment illustrates how telehealth could be helpful in expanding access. In 2016, the National Association of Mental Illness conducted a survey showing that people were far less likely to find or use an in-network mental health provider compared to other types of medical specialists.[8] These results are consistent with other studies, which found

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[5] NPRM; Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care (CMS-2408-P).
[6] Health Benefit Plan Network Access and Adequacy Model Act. National Association of Insurance Commissioners. 2015.
[7] Patient Wait Times in America: 9 Things to Know. Alyssa Rege. Becker's Hospital Review. June 9, 2017.
[8] "Out-of-Network, Out-of-Pocket, Out-of-Options". National Association of Mental Illness. November 2016.

that individuals have particular difficulty finding in-network psychiatrists. A face-to-face telehealth visit via video offers a close substitute to an in-person visit.[9]

Support Affordability and Sustainability
Role of Risk Adjustment

As CMS looks to expand the use of telehealth services to more Medicare beneficiaries we believe there is a unique value for MA plans using telehealth to manage the care and health related costs for seniors.

We ask that CMS consider extending additional telehealth flexibility to MA program beneficiaries and plans by allowing MA plans to use diagnosis codes resulting from a video telehealth encounter to count for risk adjustment purposes.

Historically, CMS has required that all ICD diagnoses submitted for risk adjustment purposes must originate from a face-to-face encounter with an acceptable provider type. In 2019, CMS began permitting MAOs to provide telehealth as an additional benefit, noting that "…the use of telehealth as a care delivery option for MA enrollees may improve access to and timeliness of needed care, increase convenience for patients, increase communication between providers and patients, enhance care coordination, improve quality, and reduce costs related to in-person care." While acknowledging the benefits and aspirational use for telehealth services, CMS, in response to comments from the industry, indicated that guidance would be forthcoming regarding telehealth benefits and its intersection with risk adjustment. We believe the time is ripe to address how diagnosis codes derived from a telehealth encounter can be used for risk adjustment.

Now, more than ever, MA beneficiaries will likely opt to use telehealth services. We believe that allowing diagnosis codes that originate from a telehealth visit to be used by plans for risk adjustment purposes is consistent with the 2022 White House statement in the Unity Agenda and Strategy which acknowledges that telehealth services are critical to the diagnoses of diseases for Medicare beneficiaries. "The use of telehealth to address mental health and substance use needs rose dramatically during the height of the pandemic and has remained above pre-pandemic levels even where COVID has waned. These tele-mental health services have proven both safe and effective, while reducing barriers to care. To maintain continuity of access, the Administration will work with Congress to ensure coverage of tele-behavioral health across health plans, and support appropriate delivery of telemedicine across state lines."

This encounter, which could normally occur in a primary care office setting can, and now often will, occur in a telehealth setting. Patients will likely forgo for the foreseeable future direct in-person routine visits with physicians and choose instead to solely interact with physicians through technology. Under the current CMS interpretation of the face-to-face rule, the diagnosis codes derived from these technology-driven encounters would not count towards calculation of

[9] "Access to Psychiatrists in 2014 Qualified Health Plans". Mental Health Association of Maryland. January 26, 2015.

risk adjusted payments for plans. This policy may result in disparate treatment for Medicare beneficiaries under Part B as opposed to Part C and serves as a significant barrier at a time when plans should be encouraging the use of telehealth services.

We believe MA plans should be encouraged to utilize video telehealth services and urge CMS to allow these encounters to constitute a face-to-face encounter under the risk adjustment rules. Recognizing the use of telehealth as a means of diagnosis capture related to risk adjustment would be the final regulatory barrier preventing telehealth from reaching its full potential in value-based care delivery for Medicare Advantage.

In closing, advances in telehealth have made health care more accessible and equitable, and we believe that these advances should remain part of our health care system after the pandemic ends. We welcome any opportunity to work more closely with CMS to ensure that no Medicare beneficiary is disconnected from their choices for quality, accessible and affordable health care.

Sincerely,

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Included Health (Doctor On Demand + Grand Rounds Health)