May 22, 2020

Administrator Seema Verma
Centers for Medicare and Medicaid Service
500 Security Boulevard
Baltimore, MD 21244

Submitted Virtually Through Regulations.gov

Dear Administrator Verma:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services' (CMS') interim final rule, "Medicare and Medicaid Programs: Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," published in the *Federal Register* on April 6, 2020, and the follow-up rule titled, "Medicare and Medicaid Programs, Basic Health Program, and Exchanges: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Program," published in the *Federal Register* on May 8, 2020.

CHIME is an executive organization dedicated to serving chief information officers (CIOs), chief medical information officers (CMIOs), chief nursing information officers (CNIOs), and other senior healthcare IT leaders. With more than 3,200 members, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate for the effective use of information management to improve the health and healthcare in the communities they serve.

We appreciate the Administration's efforts to protect both patients and providers through the flexibilities provided in both interim final rules as the nation's health system works to respond to the COVID-19 Public Health Emergency (PHE) and we applaud the agency for its rapid work to issue numerous waivers, including several related to the use of telehealth. CHIME welcomes this opportunity to lend our perspective as CMS continues to evaluate its response to the PHE and works to continue supporting our members and the patients they serve during this difficult time. We believe that further utilization of information technology and telehealth services can continue to help providers maintain safe social distancing from those yet to be impacted by COVID-19 and focus their time in their facilities on efforts to treat those who are fighting the disease.

Since the outbreak of COVID-19 began, we have heard from our members about the struggles and successes those on the front lines have experienced. A common refrain from those members is that telehealth and the ability for patients to access care at a distance is critical to fighting this disease. While those in current hotspots are working to flatten the curve by treating patients in critical need of emergency services in person, they have also highlighted the need for patients who are infected, but stable. Those who are not yet part of the growing infected population remain home to protect both healthcare workers and other patients they may come into contact with during a visit. Conversely, other members in communities yet to be heavily impacted by COVID-19 are working to prevent their infection rate from ever reaching a level that would strain their system and services. These providers continue to embrace the available flexibilities to ensure they can limit any unneeded or dangerous interactions patients and providers may

have with those who are infectious, but asymptomatic. To ensure the policies have the full impact intended, it is imperative these flexibilities are extended to additional provider types and care settings. CMS also must concurrently continue the process of evaluating and adding other Medicare telehealth services to the list of services eligible for delivery and reimbursement as audio-only telehealth services.

Furthermore, as some areas begin to see their curve plateau, providers are starting to look at what life without a PHE and COVID-19 will look like. Many concerns from our members have highlighted the enormous strain on the system that will occur once those who have delayed medical procedures seek access to care after the PHE has ended. Patients looking for care at inpatient or ambulatory facilities will come face-to-face with a healthcare delivery system that is understaffed, overwhelmed, underfunded, and struggling to manage an influx of patients while lacking healthy and equipped staff, with facilities still repurposed to handle intensive care patients. Additionally, the increased use of telehealth has moved the country further into 21st Century medicine. The flexibilities are reducing burdens on providers and patients alike and reverting to pre-COVID telehealth policies will be seen as a step backward.

With this in mind, we recommend the Administration and CMS extend the telehealth provisions outlined in this rule and implement them permanently moving forward. We furthermore strongly recommend that the availability of telehealth to a wide swath of the public not be removed abruptly following the end of the PHE. Providers have already implemented systems through need and with the help of this Administration's cross-agency efforts, including financial assistance to offset the costs of purchasing and implementing telehealth systems through programs such as the Federal Communication Commissions' (FCC) COVID-19 Telehealth Program. By making these telehealth changes permanent, CMS and the Administration will be demonstrating their support for providers and health systems that quickly pivoted from their normal practices and, in many cases, implemented costly and extensive telehealth programs. Continuing the availability of telehealth for both patients and providers will also help smooth the glide path as the American medical system transitions from COVID-19 trauma care back to standard operations, a process many continue to believe will take two years or longer[1].

Other recommendations related to the telehealth flexibilities within the above mentioned interim final rules and subsequently released regulatory guidance include:

- **Expansion of communication technology-based services (CTBS) in Medicare:** Under normal Medicare policy, CMS routinely pays for many kinds of services that are furnished via telecommunications technology but are not considered Medicare telehealth services. These CTBS include, for example, certain kinds of remote patient monitoring (either as separate services or as part of bundled services), and interpretations of diagnostic tests when furnished remotely. On an interim basis, during the PHE for the COVID-19 pandemic, CMS finalized that many CTBS under Medicare[2] can be provided to both new and existing patients, allowing for consent to be attained at the time the service is provided, and expanding the use of those service codes to additional service providers.
    - **Recommendations:** CHIME strongly supports finalizing these services and allowing the flexibility for both new and existing patients to be treated via CTBS. The ability to expand in which providers are eligible to provide CTBS, as well as those eligible to receive CTBS, is crucial to developing telehealth services. As part of these flexibilities, we also strongly support CMS' expansion of providers qualified to provide CTBS and encourage CMS to continue expanding the list in order to support wider adoption of telehealth. Additionally, we support a permanent policy that keeps these flexibilities, further supporting patients' access to care via telehealth services and further incentivizing providers to continue providing care via telehealth.

[1] University of Minnesota Center for Infectious Disease Research and Policy COVID-19 Viewpoint: https://www.cidrap.umn.edu/sites/default/files/public/downloads/cidrap-covid19-viewpoint-part1_0.pdf
[2] Codes or the services include: HCPCS codes G2010 G2012, G2061, G2062, and G2063, and CPT codes 99421, 99422, and 99423

- **Expansion of audio-only telehealth services:** Under ordinary Medicare policy, CMS does not reimburse for telehealth services performed over the telephone[3]. However, for the duration of the PHE, CMS will be finalizing payment for telephone CPT codes and also will not be enforcing the requirement for there to be an established relationship for the utilization of the CPT code. In additional guidance, CMS allowed for more services to be provided via audio-only telehealth and increased payments for these services. CMS also recognized that the way audio-only E/M services are being furnished as substitutes for office/outpatient E/M services means they should be considered as a telehealth service. CMS intends that after the conclusion of the PHE that they will halt this policy and return to the previous one, which requires an in-person visit, an official telehealth visit, or a "virtual check-in,"[4] depending on the nature and complexity of the patient's needs.
    - **Recommendations:** CHIME strongly supports waiving the non-covered descriptor for telephone services as well as the established patient relationship requirement for the utilization of audio-only telephone services. We support a permanent policy that continues these flexibilities beyond the expiration of the PHE and extension of the policy to encompass additional care services. The ability to utilize audio-only telehealth services is crucial to increasing access for many populations presently served by CMS. These populations include those unfamiliar with audio/video technology, populations whose social determinants of health factors may inhibit their ability to use telehealth, rural areas where broadband coverage and the ability to stream video both at the patient's location and at the facility are constrained or limited (i.e., rural hospitals, rural health clinics and federally qualified health centers serving both urban and rural patients).

- **Reimbursement parity for audio-only telephone services:** Under standard Medicare policy, when services are administered to a patient in a telehealth setting, no originating site facility fee is paid. As part of the interim final rule, providers are instructed to report the place of service code that would have been published had the service been furnished in person. CMS provided this flexibility as it recognizes that, as physician practices suddenly transition a significant portion of their services from in-person visits to telehealth visits in response to the PHE, the costs of furnishing these services may not significantly differ from the costs involved when these services are supplied in person. CMS also reported they understand how audio-only E/M services are being utilized and, as a result, has modified relative value units (RVUs) associated with these codes previously aligned with existing office and outpatient E/M codes. These modifications also bring audio-only RVUs closer to the reimbursement level of similar outpatient E/M codes[5].
    - **Recommendations:** CHIME strongly supports the implementation of reimbursement parity for telehealth services that would have otherwise been conducted face-to-face and strongly recommends extension of the same parity to providers utilizing audio-only telemedicine services, beyond the reimbursement flexibility already offered to providers. By not recognizing the same flexibilities for audio-only services, CMS is unknowingly punishing providers – including many rural and other underserved providers and patients – who are unable to utilize audio/video telehealth services, but are attempting to follow other Administration guidelines to limit the number of patients and providers within their facilities to lessen the spread of COVID-19. CHIME also strongly recommends CMS continue this reimbursement parity after the PHE, recognizing the increased access to care that telehealth facilitates, including audio-only services, offer to patients. This will help ensure providers are able to continue offering these services facilitated by a steady and adequate

[3] These are CPT codes (98966, 98967, 98968, 99441, 99442, 99443) which are assigned the status indicator "N" as a non-covered services.
[4] This type of service refers to a brief non-face-to-face check-in with a patient via communication technology, including assessing whether a patient is in need of an office visit which lasts between 5-10 minutes and is not related to an E/M service that occurred within the last seven days or leads to a visit within the next 24 hours or the next soonest appointment.
[5] RVUs: 0.48 for CPT code 99441; 0.97 for CPT code 99442; and 1.50 for CPT code 99443. We are also finalizing the direct PE inputs associated with CPT code 99212 for CPT code 99441, the direct PE inputs associated with CPT code 99213 for CPT code 99442, and the direct PE inputs associated with CPT code 99214 for CPT code 99443.

funding stream. Without these funding streams, services provided via these modalities may be unsustainable. While CHIME membership understands common sense parity is required and that not all audio-only services equal that of an in-patient visit, ensuring the services – such as initial visit follow-ups and treatment adjustment visits – can be delivered via an audio-only medium allows providers to offer audio-only services sustainably. Implementation of the recommendation to extend this payment parity beyond the end of the PHE could be accomplished by CMS further revising the definition of an "interactive telecommunications system" within the interim final rule to include systems that provide audio-only communication.

- **Medicare's originating site policies:** Under ordinary Medicare policy, the individual receiving the service must be located in a telehealth originating site. While most of these sites, as dictated by statute[6], are rural, several of our members consider themselves to be found in rural areas and don't meet the federal requirements. Additionally, the reimbursement for originating sites can also be an impediment as the facility fee is only approximately $27, which often is not even enough to cover the cost of paperwork. Under the interim final rule, CMS has waived the policy for an originating site such that patients can be treated via telehealth at locations other than rural ones, including their homes.
    - **Recommendations:** CHIME strongly supports waiving the originating site requirements. We furthermore recommend a permanent policy that is more flexible such that it allows patients regardless of location – including those located in urban areas – to be treated via telehealth.

- **Telehealth reimbursement for Rural Health Clinics (RHCs) and Federal Qualified Health Centers (FQHCs):** Under ordinary Medicare policy, RCHs and FQHCs may deliver care for existing patients through Virtual Communication Services lasting five minutes or more, similar to the aforementioned virtual check-ins. However, under the PHE, CMS is allowing payment for services that may be delivered and paid through virtual visits to last more than five minutes, as well as for new patients.[7] Payment for these distant site telehealth services furnished between January 27, 2020, and June 30, 2020, will be made at the RHC's all-inclusive rate (AIR) and the FQHC's Prospective Payment System (PPS) rate. From July 1, 2020, to the end of the PHE, RHCs and FQHCs will be paid at the $92 rate for telehealth services. Similar rules are in effect for Virtual Communications Services Codes[8]. CMS has also outlined that reimbursement for these services is now available to new patients, as well as existing patients.
    - **Recommendation:** CHIME supports CMS' expanded coverage of Virtual Communication Services for patients served by FQHCs and RHCs. We strongly encourage CMS to continue its ability to bill and practice telemedicine to increase patient access in rural and urban areas beyond the length of the PHE. With that in mind, we encourage CMS to expand the payment reimbursement for distant site telehealth services and Virtual Communications Service codes to ensure that RHCs and FQHCs are reimbursed at their usual rates. Without the ability to see in-person patients, reimbursing at a lesser rate penalizes the RHC and FQHC for providing these services and fails to support the investment these provider groups have made in standing up robust telehealth systems.

- **Remote Physiologic Monitoring (RPM):** Under standard Medicare policy, for RPM visits to be considered reimbursable, there must be an established patient-provider relationship, and the patient must have a chronic condition. In response to the PHE, CMS has provided flexibility for RPM by waiving both of these requirements, while also encouraging providers to discuss consent with their patients at the beginning of every virtual RPM visit rather than obtaining consent annually. Additionally, CMS has provided flexibility allowing RPM services to be billed for periods of time that

[6] Section 1834(m)(4)(C) of the Social Security Statute
[7] CMS plans to expand reimbursement of G0071, virtual communication service lasting at least five minutes to include payment for longer lasting services (99421, 5-10 minutes; 99422, 11-20 minutes; 99423, more than 21 minutes).
[8] G0071

are fewer than 16 days out of 30 days, but no less than two days for the purpose of treating COVID-19 infections.
    - **Recommendation:** CHIME supports CMS' inclusion of these flexibilities in the interim final rule to continue to protect patients and providers by limiting needed face-to-face contact. We also recommend CMS extend these flexibilities beyond the PHE to further encourage the use of telehealth in an RPM setting in the future.

- **Expansion of providers eligible to provide telehealth:** As part of the flexibilities provided by the interim final rule, CMS allows physical, speech-language, or occupational therapy services to be delivered via telehealth and further provides for physical therapists, speech-language pathologists, and occupational therapists to provide those services via telehealth through its additional guidance. CMS further expanded the number of providers eligible to bill for Medicare telehealth in their second COVID-19 Interim Final Rule. Members report, however, that there is substantial confusion around how to bill for therapy in rehab facilities.
    - **Recommendation:** CHIME strongly urges CMS to continue to increase the flexibilities on what provider types are allowed to practice via telehealth and to make those flexibilities permanent following the PHE. Continuing to support a growing list of provider types recognizes the commitment those providers have made to providing telehealth services during the PHE, and further increases access to care by those providers after the PHE concludes. Additionally, we recommend CMS work with the rehab community to provide clarification around billing to ease administrative burdens.

- **Licensure:** Under regular Medicare policies, the agency prohibits clinicians from practicing across state lines without a license in the state where they are providing a service. Our rural members have said this is a barrier to care and have also identified the costs to obtain additional licenses for each state an added restriction.
    - **Recommendation:** CHIME supports CMS waiving the licensure requirements and urges them to make this a permanent policy like the Veteran's Administration did in 2018.[9] Extending eligibility of reimbursable providers to additional clinical specialties like pharmacists, social workers, dieticians and nursing, acknowledges the role that a multi-disciplinary care team plays in overall outcomes for care across the continuum.

- **Access to broadband:** Unfortunately, many parts of the country still do not have access to broadband services, which impedes the ability of providers to deploy and utilize telehealth services. Our members continue to report this as a significant barrier that creates a digital divide in rural America and that the areas of the country deemed rural to receive broadband monies from the FCC are inaccurate. This has a spillover effect on rural healthcare providers who continue to be challenged in delivering telehealth.
    - **Recommendation:** We recommend that CMS work closely with the FCC and urge them to change the criteria by allowing localities to define and identify where broadband is deemed insufficient rather than rurality based on distance from urban areas as the deciding factor.

- **Reimbursement parity across public and private payer plans:** While CHIME is in strong support of the work CMS has done to increase access to telehealth and increase the reimbursement for providers for offering those telehealth services, our members report the inconsistent implementation of telehealth reimbursement across private payers and Medicaid – although many have noted payers are often looking to CMS for leadership. It is crucial for providers to be able to receive reimbursement parity for telehealth services delivered and billed to private payers and Medicaid. Without this parity, providers are often left in the precarious position of having to decide whether to implement systems and procedures to support individual payer patients or public payer patients. No matter what choice the provider makes, access to care is decreased to a patient group, solely based on how their healthcare is paid for. Finally, in addition to payment variances, there is significant

[9] https://www.govinfo.gov/content/pkg/FR-2018-05-11/pdf/2018-10114.pdf

variability across payers concerning coding and coverage, creating a labyrinth of policies for providers to navigate, placing undue burdens and costs on them.

- **Recommendations:** CHIME strongly encourages CMS to work across payment spectrums with all private and public payer systems to ensure there is reimbursement parity for telehealth services, including for hospital inpatient teleconsults. We also encourage CMS to provide increased clarity around the institutional reimbursement technical component that coincides with this payment parity. As the PHE continues, patients will require access to care, and providers being unable to attain consistent reimbursement for telehealth services should not be the barrier that prevents access. CHIME also urges CMS to convene public and commercial payers to work collaboratively to develop strategies for more consistency around coverage and coding. The PHE has pushed healthcare into a more digital tele-connected era, and it is crucial for payment to follow with these technological leaps to support providers in making costly upfront investments in developing a robust national telehealth system.

We appreciate the opportunity to comment and welcome the chance to help inform the critical work being done by CMS. We look forward to continuing to be a trusted stakeholder in addressing healthcare as this PHE continues to evolve. Should you have any questions about our letter, please contact Andrew Tomlinson, Director of Federal Affairs, at atomlinson@chimecentral.org.

Sincerely,

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