May 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Re: Conclusion of Flexibilities Provided During the Public Health Emergency

Dear Administrator Brooks-LaSure

On behalf of the Premier healthcare alliance serving more than 4,400 U.S. hospitals and health systems, hundreds of thousands of clinicians and approximately 225,000 other providers and organizations, we write to provide recommendations on maintaining flexibilities provided during the public health emergency (PHE) in alternative payment models (APMs). Premier maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them. Premier runs the largest population health collaboratives in the country, the PINC AI™ Population Health Collaborative, which has worked with well over 200 ACOs and is currently comprised of more than 70 ACOs.

We appreciate that HHS has indicated that it will provide at least 60 days' notice before the conclusion of the PHE. It is critical to public health and frontline healthcare providers' readiness that the flexibilities enabled by the PHE remain in place until we have greater certainty that COVID-19 will no longer require surge response capabilities to be rapidly scaled up. We also understand that planning for the future during the current lull in the crisis is important. As you prepare for the eventual conclusion of the PHE, we urge you to consider (1) testing flexibilities provided during the PHE through the Medicare Shared Savings Program (MSSP) and Innovation Center models and (2) extending certain flexibilities where CMS has regulatory control.

INNOVATION CENTER MODELS

Several of the waivers under the PHE warrant additional testing through Innovation Center models or through adjustments to existing waivers.

Hospital at Home. More than 200 hospitals across 34 states—including many health systems in the Premier alliance—have embraced the "hospital at home" concept and have tailored their programs to meet specific patient and organizational objectives. The Acute Hospital Care at Home (AHCAH) program enables providers to effectively monitor and care for patients as they recover in the comfort of their own homes. This can include remote monitoring capabilities, in-home provider visits, telehealth, medication management, and many other care strategies. This new avenue of care has freed up hospital capacity, offered a safe and effective method to care for COVID-19 patients and reduced avoidable emergency department visits. Recent studies show this approach is leading to lower rates of mortality and readmissions[1],[2] along with improved patient satisfaction. Additionally, Hospital-at-Home stays cost 25 percent less than care furnished in a facility[3].

[1] Caplan G.A., Sulaiman N.S., Mangin D.A., et al. A meta-analysis of "hospital in the home". Med J Aust. 2012 Nov 5;197(9):512-9. doi: 10.5694/mja12.10480. PMID: 23121588. Accessed at https://www.mja.com.au/ journal/2012/197/9/meta-analysis-hospital-home
[2] Levine D.M., Ouchi K., Blanchfield B., et al. HospitalLevel Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020 Jan 21;172(2):77- 85. doi: 10.7326/M19-0600. Epub 2019 Dec 17. PMID: 31842232. Accessed at https://www.acpjournals.org/ doi/10.7326/ M19-0600.
[3] Caplan, et al.

Premier member health systems want to sustain these care innovations and carry their programs forward once the pandemic subsides. **To further test the hospital at home concept, we encourage CMS to develop a new APM and provide current ACOs the flexibility to implement hospital at home programs.**

Telehealth. While MSSP and other Innovation Center waivers contain telehealth waivers, APM participants have used them in a very limited capacity due to strenuous reporting requirements. When providers are held accountable for total cost of care and quality, the program integrity concerns related to telehealth are mitigated. We urge CMS to provide maximum telehealth flexibilities to providers in APMs and increase those flexibilities with adoption of risk. Specific areas to consider maintaining are:

- *Expanded set of services.* CMS established a process to temporarily add numerous services to the telehealth list during the PHE while CMS builds the evidence base for permanent inclusion. This policy will conclude in CY 2023. The current telehealth waivers limit APMs to services available on the existing telehealth lists. CMS should similarly view APMs as an opportunity to test expansion of telehealth services by creating a list of covered telehealth services specifically for APMs. This would allow APMs to retain the full list of services provided during the PHE while CMS builds the evidence base needed for broader adoption.
- *Frequency limits.* As part of the PHE, CMS waived frequency limits on certain services furnished via telehealth: subsequent hospital care, subsequent nursing facility care, and critical care consultation services. Under a fee-for-service construct, these limits may help ensure patients receive proper in-person care and that bad actors do not abuse billing for these services. These protections are inherent to APMs, however, which are already incented to provide care in the most appropriate setting to ensure the best outcomes.
- *Established patient requirements.* Several of the virtual and telehealth services require that a patient receive in-person services from a practitioner within a certain time period in order to be eligible for services to be delivered remotely. Under the PHE, CMS waived many of these requirements to allow practitioners to furnish virtual and telehealth services to both established and new patients. For APMs where beneficiaries voluntarily align or are prospectively assigned, this requirement would limit beneficiary access to receiving telehealth from all of the APM's participant providers. For example, there may be instances where a provider, such as a specialist, could furnish appropriate care to a patient who may be new to the specialist but has already received in-person care from another provider within the APM.
- *Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) ability to furnish services.* While RHCs and FQHCs can serve as a site where patients can receive telehealth services ("originating site"), statute has restricted them from serving as the site where practitioners can furnish telehealth services ("distant site"). During the PHE, Congress enacted legislation which allows RHCs and FQHCs to serve as distant sites[4]. RHCs and FQHCs are a critical source of care for many patients in underserved communities. Expanding this flexibility would improve access and continuity of care for patients who rely on RHC or FQHC services. In the absence of Congressional action, we urge CMS to allow for RHCs and FQHCs that are participating in APMs to serve as distant sites for telehealth services.

SNF 3-Day Rule. CMS has waived the requirement that Medicare beneficiaries have a 3-day hospitalization to be eligible for skilled nursing facility (SNF) services under the PHE. The MSSP and several Innovation Center models utilize a similar but more burdensome waiver. Under these existing waivers, providers must meet certain documentation requirements and are only eligible for the waiver if patients are discharged to certain facilities. CMS should streamline the Innovation Center and MSSP waivers to match the waiver granted under PHE.

MODERNIZING THE TELEHEALTH BENEFIT

[4] Under the Consolidated Appropriations Act, 2022, this flexibility will stay in place for an additional 151 days following conclusion of PHE.

Telehealth has been a critical tool during the PHE, allowing providers to continue to furnish much needed services to patients from the safety of their home. The flexibilities that CMS has granted around telehealth have served to highlight that many services can be effectively and efficiently furnished remotely. Moreover, according to a Premier survey of health systems administered, 93 percent of respondents supported making these waivers permanent.

Several Medicare requirements restrict providers from adopting telehealth more broadly outside the emergency period. While we appreciate Congress has extended the telehealth flexibilities 151 days post- PHE, we believe there are several actions that CMS can take to improve telehealth long term.

Technology. As part of the PHE, CMS waived requirements to allow for certain services to be furnished through audio-only technology. Accessing video technology can be particularly challenging and creates barriers for beneficiaries who are low-income, elderly, or who live in rural areas where the broadband infrastructure cannot support streaming video. These challenges will persist even after the emergency period. The PHE has highlighted that many services can be effectively delivered as audio-only and do not require a video-connection. Specifically, CMS should modify its definition of "interactive telecommunications system" (410.78(a)(3)) to allow for use of audio-only technology for services where it would be clinically appropriate. CMS could continue to differentiate which services are eligible to be furnished via audio-only as compared to those that require both audio and video technology. CMS should provide stakeholders with the opportunity to weigh in on these lists as part of annual rulemaking. **We encourage CMS to maintain flexibilities to allow certain services to be furnished via audio-only telehealth**

Telehealth and other remote services furnished by other providers. The PHE has highlighted the effectiveness of furnishing services via telehealth across multiple providers. CMS has granted flexibilities to allow for post-acute care providers to furnish additional services remotely, such as allowing home health agencies to use technology to furnish more services within an episode of care. Additionally, CMS has also waived certain conditions of participation and provider-based requirements to allow hospitals to furnish services to patients in their home remotely. While these outpatient services are not technically considered telehealth services, they are furnished in the same manner as telehealth services. Several of the services are also similar to services that can be furnished by physicians through telehealth.

Telehealth services are usually billed on a professional claim, which has been a limiting factor for allowing other types of providers to furnish telehealth services, even under the PHE. In some cases, services furnished via telehealth would be captured in an episode and included in a Medicare payment. However, there are other instances where providers would not be paid for services furnished remotely. **We encourage CMS to continue to explore what regulatory and statutory changes are necessary to allow other provider types, such as institutional providers, to allow to furnish and bill for telehealth services.**

STREAMLINING WORKFORCE REQUIREMENTS

As part of the PHE, CMS waived several requirements related to scope of practice to ensure providers can fully maximize their workforce. For example, CMS waived requirements that a certified registered nurse anesthetist be under the supervision of a physician. These waivers had the effect of deferring policy to state laws and requirements related to supervision and licensure.

Oftentimes, Medicare scope of practice requirements are duplicative of existing requirements at the state level and, in some cases, may be more stringent. This can be overly burdensome to providers as they track various requirements to ensure compliance. **CMS should explore streamlining its scope of practice requirements to remove unnecessary and overly burdensome requirements that are duplicative of state or licensing board efforts**.

Additionally, CMS revised the definition of direct supervision for the duration of the PHE to allow for direct supervision to be provided using real-time interactive technology that has audio and video capability, or a virtual presence. Direct supervision requires that a physician or other practitioner be immediately available when services are being furnished to Medicare beneficiaries. Advances in technology allow physicians and other practitioners to stay connected virtually, which in some cases may be more expeditious and efficient than if the practitioner was physically present. **We encourage CMS to provide practitioners with the discretion to determine the best means of providing appropriate direct supervision**. At a minimum, CMS should explore allowing direct supervision to be met through virtual presence for certain services.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit comments for consideration regarding regulatory flexibilities provided during the COVID-19 pandemic response that should be maintained beyond the expiration of the public health emergency. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, vice president, policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance