Illinois Health and Hospital Association

October 5, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

Re: CMS-1734-P, CY 2021 Payment Policies under the Physician Fee Schedule (85 FR 50074)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the calendar year (CY) 2021 Medicare Physician Fee Schedule (PFS) proposed rule. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis in the development of this rule, and we value the administration's collaboration as we work to ensure the provision of effective and quality healthcare for all Illinoisans. This is particularly true as hospitals across the country, including in Illinois, continue staffing the front lines to maintain the health and safety of our communities as the COVID-19 public health emergency (PHE) persists. Our members require continued flexibility and financial support not only during the PHE, but also long after it is over as healthcare providers join other industries across the country in rebuilding from the economic devastation that has accompanied and exacerbated the tragic health toll this virus has exacted on Americans.

To that end, the American Hospital Association (AHA) projects hospitals will experience at least $323 billion in COVID-19 related financial losses in 2020,[1] a sum that will continue growing in 2021 as the pandemic continues. In fact, patient volumes for many specialties remain below 2019 levels, with inpatient procedures and surgeries down 18.6% cumulatively as of August.[2] Telehealth offers both providers and patients a means to safely and effectively access primary and specialty services during this time, and CMS is integral in ensuring flexibilities and resources to connect providers and patients through technology.

[1] https://www.aha.org/system/files/media/file/2020/06/aha-covid19-financial-impact-report.pdf
[2] https://www.modernhealthcare.com/care-delivery/inpatient-volumes-surgeries-continue-lag-amid-covid-19

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Telehealth services are particularly important for Medicare beneficiaries, who are at higher risk for COVID-19 related complications and mortality. Early in the pandemic, Congress and the U.S. Department of Health and Human Services (HHS) temporarily lifted longstanding barriers to telehealth expansion in Medicare. These flexibilities have been essential in enabling seniors to maintain access to services while also allowing hospitals to meet surge capacity, and protected beneficiaries and healthcare workers against unnecessary exposure to the virus when community spread was at its highest. According to an HHS report issued in July 2020, nearly half (43.5%) of Medicare primary care visits were provided via telehealth during April, compared with less than one percent prior to the pandemic.[3] By the end of April, more than 1.5 million Medicare beneficiaries in traditional Medicare accessed care through telehealth, compared to just 11,000 during the week ending March 7.[4,5] Medicare Advantage plans also expanded access to telehealth services during this time and found that 91% of seniors reported a favorable experience.[6]

Expanded coverage and payment of telehealth in Medicare benefits seniors by removing barriers to access, such as out-of-pocket costs and transportation to in-person appointments, reducing unnecessary emergency department and urgent care visits, and limiting exposure of a vulnerable population to COVID-19 and other viruses. Hospitals and health systems have rapidly increased access to virtual services by investing in new technology, adjusting clinical overflows and educating staff, patients and clinicians. **We urge CMS to use its authority and influence to indefinitely maintain and expand telehealth access granted during the public health emergency (PHE).**

We strongly support CMS' proposal to add a Category 3 when considering services eligible for telehealth during the PHE that may eventually meet Category 1 or 2 eligibility. We agree with CMS' proposed criteria for determining whether there is a clinical benefit to include a service on the telehealth list on a Category 3 basis. We also agree that establishing a longer timeline for compiling evidence of clinical benefits would be prudent, given the numerous issues currently requiring the attention of physicians providing telehealth services.

At the same time, we urge CMS to consider revising current requirements for adding services to the Medicare telehealth list, as a 2019 federal systematic review of telehealth for acute and chronic care consultations found that telehealth generally produces either better or similar outcomes to in-person visits in the settings and clinical indications studied.[7] In particular:

- Remote intensive care unit consultations likely reduce mortality;
- Specialty telehealth consultations likely reduce patient time in the emergency department;

[3] https://aspe.hhs.gov/system/files/pdf/263866/HP_IssueBrief_MedicareTelehealth_final7.29.20.pdf
[4] https://www.healthcaredive.com/news/medicare-seniors-telehealth-covid-coronavirus-cms-trump/578685/
[5] https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/
[6] https://www.bettermedicarealliance.org/news/poll-seniors-give-telehealth-high-marks-medicare-advantage- satisfaction-smashesnew-record-2/
[7] https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/cer-216-telehealth-final-report.pdf

- Telehealth consultations in emergency services likely reduce heart attack mortality; and
- Remote consultations for outpatient care likely improve access and clinical outcomes.

Illinois hospitals executed these findings by providing patients effective access to telehealth services approved by CMS for the duration of the PHE. The efficacy of telehealth is clear in the examples below, which demonstrate why we believe improved flexibility for use and reimbursement of telehealth services should continue moving forward.

First, CMS seeks comment on who is providing and using telehealth services during the PHE. IHA recently surveyed member hospitals and health systems on their use of telehealth, and the results show that the types of providers and patients benefiting from telehealth services vary widely, touching both primary and specialty care and positively impacting patients of all ages. For example, La Rabida Children's Hospital of Chicago successfully transitioned over 70% of in-person outpatient appointments to telehealth when the COVID-19 public health emergency necessitated alternative care access for risk management. Using real-time audio-visual technology, patients – many with medically complex conditions – have access to everything from primary and specialty care appointments, behavioral health services, and even wheelchair deliveries.

Northwestern Medicine of Chicago expanded telehealth services for all patients, but they have been especially helpful for bed-bound patients who require Medivan in order to travel. Additionally, Northwestern found the flexibilities for types of communication used by patients and practitioners have expanded access for patients who struggle with certain types of technology and/or lack access to video technology due to financial constraints.

Advocate Aurora Health, OSF Healthcare in Peoria and Southern Illinois University School of Medicine, two of which serve more rural Illinoisans, are using telehealth to provide basic triage, patient monitoring, and behavioral health services to individuals with a suspected or confirmed COVID-19 diagnosis. Specifically, Pandemic Health Workers virtually visit individuals experiencing symptoms or who tested positive for the coronavirus, and provide education and wellness kits that include items critical to monitoring symptoms, recovering at home, and preventing virus spread such as thermometers, pulse oximeters, blood pressure cuffs, alcohol wipes and masks. Pandemic Health Workers are also able to virtually connect patients to social services such as food, housing and transportation services.

Additionally, Hospital Sisters Health System (HSHS) based in Springfield, Illinois, expanded use of telehealth for both inpatient and outpatient services, even acquiring technology to make it easier for patients to utilize virtual care services. HSHS provides a new wellness program through telehealth appointments to assist with individuals isolated at home. The program provides telehealth appointments to improve quality of life through light physical exercises, positioning and breathing exercises to increase physical function, activity level and reduce

fatigue. The hospital system also waived fees for use of its Anytime Care virtual visits related to screening and evaluation of COVID-19.

CMS also seeks comment on the use of telehealth to gather specific health outcomes and demonstrate clinical benefit. Behavioral health services delivered via telehealth provide an excellent example of the intersection of care delivery and technology. OSF Healthcare in Peoria moved to operationalize a behavioral health app that integrates live and pre-programmed support for both patients and OSF workforce. According to OSF,[8] the app is a clinically validated resource that delivers cognitive behavioral therapy content, but also has live, clinical connection capabilities to provide periodic check-ins and real-time assistance if needed. The number of clinically valid technological platforms for the delivery of services such as behavioral health will only grow in our new normal. It makes sense to provide these services to Medicare beneficiaries, particularly as baby boomers and the generations that follow them become more technologically literate and dependent. Such services also provide physicians with more health data to aid in the diagnosis and treatment planning of individual patients.

Regarding the retention of physical therapy (PT), occupational therapy (OT) and speech language pathology (SLP) services on the Medicare telehealth list, we understand and appreciate CMS' hesitation in adding these services to the Medicare telehealth list permanently or on a Category 3 basis. However, we urge CMS to reconsider. First, as CMS points out, certain physicians and non-physician practitioners (NPPs) are able to deliver these services via telehealth, and preserving that capability expands access to care.

Additionally, there is widespread discussion around improving and expanding telehealth service delivery. We urge CMS to work with Congress to grant authority to expand the list of practitioners eligible to bill for the provision of telehealth services to Medicare beneficiaries to include physical therapists, occupational therapists, and speech language pathologists. By retaining PT, OT and SLP services on the Medicare telehealth list now, practitioners and patients will be better positioned to transition to virtual care should such changes be made.

We also support CMS' proposal to permanently adopt the PHE allowance for certain professionals to bill online assessment and management visits (G2061-G2063) for professionals such as licensed clinical social workers, clinical psychologists, PTs, OTs, and SLPs. These communications technology-based services are important for the health and quality of life of Medicare beneficiaries, and we believe reimbursing appropriate practitioners for the delivery of these services via technology is a meaningful way to improve access for Medicare beneficiaries. Should CMS finalize this proposal, we believe CMS should certainly create detailed guidance on services that are telehealth versus communication technology-based, differences in billing implications for these types of services, and flexibility in process for adding service coverage as technology continues to improve and become more invaluable to both providers and patients.

[8] https://www.healthleadersmedia.com/innovation/how-osfs-6-digital-approaches-handle-more-50000-covid-encounters

Similarly, reimbursing certain audio-only virtual check-ins is a critical step toward expanding and improving access for Medicare beneficiaries. We support CMS' proposal to develop coding and payment for virtual check-in audio-only services with longer time units and higher values. We believe this is a meaningful precursor to allowing payment for audio-only evaluation and management services, and urge CMS to continue this path of coverage expansion, which can reduce unnecessary, higher-cost services by treating a patient at the right time and in the right setting.

As demonstrated above, the telehealth flexibilities granted during the COVID-19 PHE have already become integral to the way healthcare is delivered not only during times of hardship, but almost certainly in the coming years when we enter our new normal. The value of meeting people where they are at is long-established in the healthcare community, and is particularly important when serving older, more vulnerable populations that may experience challenges in accessing in-person services. We applaud the steps CMS has taken thus far to expand telehealth during the PHE, and urge CMS to continue down this path.

Ms. Verma, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association