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July 13, 2020

VIA ELECTRONIC SUBMISSION

Re: The Taskforce on Telehealth Policy's request for comments

The Medicare Rights Center (Medicare Rights) is pleased to submit comments in response to the Taskforce on Telehealth Policy's call for feedback on telehealth services and policies. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

General comments

Because of the risks COVID-19 poses to many people with Medicare, Medicare Rights greatly appreciates the efforts of Congress and the Centers for Medicare & Medicaid Services (CMS) to streamline and enhance Medicare coverage of telemedicine during the public health emergency. People with Medicare must retain access to necessary treatment and evaluation while being able to stay in their homes for safety. But rushed policymaking can yield undesirable results such as perverse incentives and exacerbated inequities. Going forward, we urge a cautious, thoughtful, and evidence-based approach that centers the unique and evolving needs of people with Medicare. To allow time for that, we support a glide path—and contemporaneous heightened oversight—that prevents a beneficiary's access to services from ending the moment a public health emergency declaration does.

Our National Helpline gives us insight into the struggles many people with Medicare face as they try to access high-quality, affordable care. Before the COVID-19 pandemic, many

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beneficiaries were ineligible for telehealth but could not easily travel to providers for care. For example, we heard from callers with autoimmune disorders and those taking immunosuppressants. These conditions and medications make individuals more susceptible to viral, bacterial, and fungal infections, and such susceptibility will not end with the public health emergency. Services like telehealth allow those with compromised immune systems to continue to correspond with providers for routine care, follow-ups, and prescription refill appointments, among other services, without having to put themselves at grave risk. The enhanced availability of telemedicine can ease burdens on caregivers, transportation services, and the beneficiaries themselves in both rural and urban areas. Callers to our helpline report both greater access to care and more willingness to seek care under the new system.

In other circumstances, beneficiaries were eligible for Medicare-covered telehealth but lacked the technology or bandwidth necessary for video communication. The changes implemented by Congress and CMS have helped many people access remote care, but existing disparities in access to technology and robust internet have only been exacerbated by the new rules. We must find ways to lessen such disparities in access to care.

We have also heard from many helpline callers that their providers are very confused about how to bill for these services, and how or if they can be reimbursed by Medicare. We must have additional outreach—by both the administration and stakeholders—on telehealth and other services provided via technology to ensure that Medicare beneficiaries are not subject to bills for services they were told would not incur charges.

We recognize the potential of telehealth expansion and urge all stakeholders to prioritize the needs of people with Medicare to ensure existing disparities are reduced rather than exacerbated. In addition, we must not incentivize telehealth so much that people with Medicare lose access to in-person treatment and consultation when they wish it. Beneficiaries will vary in their comfort with telemedicine and we should not substitute online access for in-person access.

We propose to subject all telemedicine and remote care policies and rules to a five-part test. Policies must:

1. Include beneficiary protections and oversight;
2. Be clinically appropriate and supported by evidence;
3. Increase access through supplementing, not supplanting, in-person care;
4. Promote health equity; and
5. Include glide paths where necessary to ensure seamless transitions.

1. Beneficiary Protections and Oversight

All coverage for remote care should include robust beneficiary protections and oversight at the outset to ensure that the care delivered is appropriate and meets the needs of the

beneficiaries. Policies that lead to poorer outcomes, reduced access to in-person care, or widespread disparities should be modified or sunsetted.

2. Clinically Appropriate and Supported by Evidence

All services and modes of communication should be clinically appropriate for the populations Medicare serves. Only services that can promote outcomes that are largely on par with in-person services should be covered. New services that may not initially have data to support them must be rigorously studied on roll out and sunsetted quickly if the evidence points to their lack of clinical efficacy.

3. Increase Access by Supplementing, Not Supplanting, In-Person Care

Many beneficiaries may prefer face-to-face visits or may have technology hurdles that make telemedicine unworkable, burdensome, or uncomfortable. We should not substitute online access for in-person access and network adequacy must not rely on care that is only available through telemedicine. Telehealth must not be incentivized so much that people with Medicare lose access to in-person treatment and consultation and must not substitute for making in-person offices and facilities accessible to people with disabilities.

4. Promote Health Equity

Existing health disparities could be exacerbated by a move to more telehealth without careful study and planning. In general, we caution that even if every temporary telehealth change were made permanent, many beneficiaries would still be left behind. Too many older adults and people with disabilities lack access to or comfort with the devices and internet services that are a necessary component of telemedicine.

Telehealth expansion efforts must confront these challenges by promoting health equity. Such policies must intentionally narrow gaps in technology access and use. This includes by directing funding, supports, and programs to low-income and underserved populations (e.g., low income senior housing), as well as to those with limited experience with or access to technology.

Meaningful reforms will also require making changes well beyond the scope of the Medicare program such as improving the nation's telecommunications infrastructure—telecommunications platforms, reliable and affordable internet and phone access, and access to needed devices—and health care workforce capacity.

5. Glide Paths Where Necessary to Ensure Seamless Transitions

Some telehealth services and flexibilities must be sunsetted. This may be due to the termination of the public health emergency or after a determination that a telehealth service or policy is not clinically appropriate or is not in the interest of beneficiaries. CMS and Congress must work together to establish a reasonable transition period after the PHE, to ensure coverage for virtual services does not end abruptly or otherwise put people with Medicare at risk.

I. Promising Policies

As noted above, any extensions to remote care coverage must pass the five-part test and be done thoughtfully, with data. Only clinically appropriate policies that prioritize beneficiary choice and access and reduce health disparities should be promoted.

Waiver of Geographic and Site Restrictions. We support the elimination of the geographic and originating site restrictions. Eliminating these restrictions will increase access to care for beneficiaries in both rural and urban settings and reduce burdens on caregivers and transportation services.

Eligible Providers and Patients. Given appropriate clinical and evidentiary support, we support the ability to provide telehealth services for both new and established patients as well as the removal of all distant site practitioner restrictions. As with other expansions of telehealth, these changes should be accompanied by robust oversight and data collection to ensure that beneficiaries are receiving the care they need.

Audio-Only Services. We urge stakeholders to consider ways to safely, permanently extend remote care to those who lack video capabilities. Many people with Medicare do not have access to the technology or strong internet signals that would allow useful video communication. Requiring video for telehealth services may prevent those who lack the equipment or internet (including low-income individuals and those in rural and some urban areas) from accessing telehealth and other remote care.

In particular, we support the provision of audio-only Opioid Treatment Program services and behavioral health counseling and education. Other care that can be delivered safely and effectively using audio-only interfaces should also be permitted. The determination of other covered care and providers should rely on clinical determinations and outcomes, and all decisions to cover audio-only care should be subject to the same rigorous and ongoing oversight and data collection as decisions to expand the list of eligible providers.

II. Policies That Require Additional Study

Hospice. CMS has amended the hospice regulations on an interim basis to specify that hospices may provide services via a telecommunications system if it is feasible and appropriate to ensure that Medicare beneficiaries receive reasonable and necessary care. In general, we support these amendments and urge additional study to determine whether such technological services should be available after the end of the public health emergency.

Payment Parity. CMS is currently paying the in-person rate for services furnished via Medicare telehealth, including audio-only telehealth, if the services would have been furnished in person if not for the public health emergency. We understand the need to maximize access to telehealth during this time. However, we do have concerns that adopting this payment structure on a more permanent basis may create financial incentives for providers that inadvertently put beneficiary health and agency at risk. To inform any future policymaking, we

must collect, synthesize, and make publicly available data examining the effects of any payment system changes on beneficiary choice and access to in-person care.

Frequency Limitations. We await further evidence regarding whether the changes in frequency limitations below should be made permanent and encourage stringent oversight while they are in place:

- **Subsequent Care Services in Inpatient and Nursing Facility Settings**. While we support the temporary relaxation of this rule to protect residents during the public health emergency, we urge close monitoring of outcomes for beneficiaries to ensure that removing this requirement is clinically appropriate and that the feasibility of fulfilling all of the required elements of a service via communication technology is borne out by evidence. We understand that providers may prefer fewer restrictions, but that does not mean that a permanent relaxation of these limitations is in the best interests of beneficiaries.
- **Critical Care Consultations and Required “Hands-on” Visits for ESRD Monthly Capitation Payments**. Similarly, regarding critical care consultations and hands-on visits for ESRD monthly capitation payments, we urge the collection of data and assessment of outcomes for beneficiaries under the new system. Decisions must be based on the clinical appropriateness of a permanent easing of these requirements once the public health emergency has ended.

III. Policies that Should Revert to Pre-COVID-19 Standards

Available Telehealth Services. During the public health emergency, CMS is updating its list of allowed telehealth services via a sub-regulatory process rather than the established regulatory process. We urge stakeholders to support a reversion to the full regulatory process as soon as possible to ensure true notice and opportunity to be heard on these important decisions.

HIPAA. CMS is allowing individuals to access telehealth using interactive apps with audio and video capabilities such as smart phones and tablets. The agency has determined that this requires enforcement discretion related to HIPAA. HIPAA enforcement should not be permanently waived and non-HIPAA compliant devices and apps such as Skype or FaceTime must not be permitted to benefit from the use or sale of health information.

Cost Sharing. HHS is permitting physicians and other practitioners to waive cost-sharing obligations for telehealth services. While we appreciate this attempt to increase access to telehealth during the public health emergency, we want a return to standardized cost sharing. Numerous reports on our National Helpline reveal that beneficiaries are facing widespread confusion and, in some cases, misinformation from providers about their cost-sharing obligations. This has led to some beneficiaries receiving bills that they were not expecting because their providers had assured them the services would not lead to cost sharing. Allowing

providers the discretion to waive cost sharing can also contribute to discrimination and health inequities.

In the immediate term, we urge both stakeholders and CMS to do more education and outreach to providers to ensure that beneficiaries are not left with surprise bills for services, particularly around the difference between services for which Original Medicare or Medicare Advantage plans must cover a service at 100% and those for which providers may waive cost sharing. We must also ensure plans and providers are not engaging in deceptive marketing, outreach, or billing practices, however unintentional. Because of the inconsistency and confusion that have resulted from this policy, we support its sunset alongside the public health emergency.

Obtaining Beneficiary Consent. With respect to telehealth provided via Rural Health Clinics and Federally Qualified Health Clinics, CMS is allowing practitioners to obtain a beneficiary's consent at the time the services are provided, as well as allowing staff to obtain the consent. We view this policy with significant caution. We urge CMS to monitor beneficiary consent to receive services very closely to ensure that beneficiaries are truly agreeing to the services and concomitant cost sharing. Callers to our National Helpline reveal that there is widespread confusion among providers as to how cost sharing works for remote services, and there is a strong potential for beneficiaries to agree to services without understanding what financial obligations they may be incurring. Beneficiaries must not be expected to pay for services if they are given inaccurate or misleading information, for example if they are told there is no cost sharing associated with them.

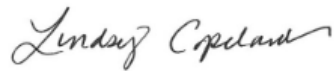
Waivers of Face-to-Face and in-Person Requirements. CMS has temporarily relaxed certain face-to-face visit requirements. While these changes may be appropriate during the public health emergency to protect beneficiaries and their providers, they must not be made permanent:

- **Hospice.** CMS has determined that a face-to-face visit solely for the purpose of recertification for Medicare hospice services is considered an administrative requirement and could be performed via telecommunications technology as a result of the PHE for the COVID-19 pandemic. We support this determination but only for the duration of the public health emergency. We do not believe this change should be made permanent.
- **Inpatient Rehabilitation Facilities (IRFs).** CMS is temporarily allowing the face-to-face visit requirements for IRFs to be conducted via telehealth to safeguard the health and safety of Medicare beneficiaries and the rehabilitation physicians treating them. We support this temporary modification of the face-to-face requirements, but do not support it as a permanent change.
- **National Coverage Determination (NCD) and Local Coverage Determination (LCD).** CMS has waived face-to-face and in-person requirements for evaluations, assessments,

certifications or other implied face-to-face services for NCDs and LCDs for the duration of the coronavirus public health emergency. While we recognize the need to reduce person-to-person contact, we are encouraging CMS to reinstate these requirements at the end of the emergency.

Thank you again for the opportunity to comment on telehealth policies. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

A handwritten signature in cursive script that reads "Lindsey Copeland".

Lindsey Copeland
Federal Policy Director
Medicare Rights Center