July 31, 2018

Ms. Seema Verma
Administrator
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Re: ACHP Recommendations to CMS for Regulations Implementing Telehealth Provisions of the Bipartisan Budget Act (P.L. 115-123, Sec. 50323)

Dear Administrator Verma:

Thank you for your leadership in reducing barriers to telehealth in the Medicare program. Given that Medicare Advantage (MA) has not faced as many statutory barriers to telehealth adoption as Medicare fee-for-service, health plans participating in the program have been able to clearly demonstrate the value that telehealth can bring to patient care.

Members of the Alliance for Community Health Plans (ACHP) are non-profit, provider-aligned health plans providing coverage in all lines of business for more than 21 million Americans across 32 states and the District of Columbia. Our plans use telehealth to strengthen the health care systems in their communities by improving access to care, increasing quality, realizing cost efficiencies that translate into better value, and facilitating a better customer experience for their beneficiaries, including not just beneficiaries who prefer the convenience of telehealth but also those who face challenges such as finding transportation to and from office visits. Please see *Attachment 1* for examples of telehealth use by ACHP member plans.

Given the clear benefits of technology-based care, ACHP plans led the effort in Congress to make telehealth a basic benefit in MA. While the supplemental status of the telehealth benefit offered an opportunity to test the technology's efficacy, there were significant challenges with administering the benefit. We were very pleased to see Congress include the MA telehealth provisions in the Bipartisan Budget Act (BBA).

The new law perfectly complements CMS's recent actions to provide Medicare beneficiaries with new options for coverage in fee-for-service; together these steps significantly modernize the Medicare program. As CMS implements the BBA provisions for the 2020 plan year through regulation this fall, ACHP offers the following recommendations. These recommendations have grown out of the experience our plans have had with telehealth as an MA supplemental benefit and in other lines of business.

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Overall, we encourage you to interpret the statute broadly, relying on the evidence-based judgment of physicians and other health professionals to determine whether telehealth-based care is medically appropriate rather than adopting a set of specific procedural codes that may unintentionally stymie innovation. We are concerned that reliance on fee-for-service codes would deter the use of new and emerging technologies and limit the growing list of use cases in which telehealth can be used safely and effectively.

1. **Telehealth as modality.** Telehealth is a modality for delivering already covered benefits in Medicare, not a separate benefit. As an example, evaluation and management services for an established patient are a covered benefit and should be recognized for payment whether they are delivered in person or through telehealth. We urge you not to create a subset of "new" benefits for telehealth, but rather allow telehealth to be broadly used for Part B services based on the judgment of the clinician.

2. **Technology neutrality.** We urge you to be consumer-friendly and technology-neutral in the implementation of BBA rules to allow for inclusion of emerging and future technologies.

3. **State consumer protections/regulation of practitioners.** States have primary responsibility to license, monitor and discipline practitioners. We encourage CMS to rely on consumer protections inherent in these state laws and licensure requirements, which apply to both in-person services and telehealth-based services. Please see *Attachment 2* for a summary of these state protections.

4. **Recognition of usefulness to all licensed providers.** The use of telehealth in patient care should be available to all licensed providers to use to the full extent of their scope of practice; telehealth models cited in Attachment 1 utilize a range of health professionals. Restricting telehealth services to physicians only would limit access for many beneficiaries.

5. **Performance Measurement, Reporting & Risk Adjustment.** The same criteria for monitoring quality, coordination, continuity of care and patient satisfaction in MA plans should be extended to telehealth. Of course there may be adjustments for technical specifications, which CMS can work with measure stewards to devise, but overall it is not necessary to create new measures for telehealth-based care. The Encounter Data System should accommodate submission of telehealth encounters, and telehealth encounters should be counted for the calculation of risk adjustment.

6. **Provider Contracting.** MA plans should be expected to include in their provider contracts requirements that telehealth encounters be recorded in the patient's medical record and, if specialty or other care, transmitted to the patient's primary care provider.

7. **Network Adequacy.** We encourage CMS to revise network adequacy standards to reflect the greater access and convenience that can be provided through telehealth. With appropriate safeguards, network standards should no longer be constrained by time and distance requirements when technology greatly extends the reach of providers. The National Association of Insurance Commissioners (NAIC) has recognized in a revised model law 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." The Veterans Administration has recently reduced significant barriers to telemedicine for purposes of ensuring providers are available throughout the country, and it serves as a good model.

8. **Capital and infrastructure costs**. Until there is data available on the capital and infrastructure costs of telehealth services, CMS should identify information sources that can be used to derive a national/industry average capital and infrastructure cost as a percentage of the cost of telehealth encounters. One approach is to apply those percentages to the bids of MA plans offering telehealth-based services in their basic benefit package.

9. **Continuity of Information.** CMS should require vendors of electronic health records to facilitate the acceptance of data from telehealth platforms. Currently, some vendors do not accept health data into their EHR from other platforms; this is not justified from a technical perspective and creates a critical choke point for telehealth progress and innovation.

10. **Building on existing evidence base.** Health plans have conducted their own studies using individual plan data, but CMS should move as quickly as possible to develop data collection and reporting that will further build the evidence base for use of telehealth in Medicare in terms of clinical outcomes, patient access and experience, and cost. The reporting requirements should be designed to minimize the administrative burden on providers and MA plans.

Thank you again for your leadership on this important issue. We would welcome additional discussion of our recommendations and would be pleased to present about our member plans experience to date in using this technology if that is helpful while you and your team develop the BBA implementing rules.

Sincerely,

Ceci Connolly
President and CEO

Attachment 1
Examples of Telehealth-Based Services Provided by ACHP Member Plans

1. Intermountain/SelectHealth: Digital Diabetes Prevention Program

Intermountain Healthcare and its SelectHealth Plan partnered with Omada Health for a pilot study of a digital diabetes prevention program for patients with confirmed pre-diabetes. The program includes e-coaching, peer support, health education, nutrition and exercise tracking, and electronic nudging meant to encourage program adherence. Participants are matched with a group of peers online and led by a coach, who they can text or email. Nearly 75 percent of those who started the program completed 9 or more sessions. The average weight loss for this group at six months was 10.7 lbs—a nearly 5 percent weight loss from the baseline—and 25 percent saw a more than 7 percent weight loss. Losing 7 percent of body weight can reduce the risk of developing diabetes by nearly 60 percent. Intermountain physicians hope to encourage more patients to try digital diabetes prevention programs, as the pilot program confirms the success of providing patients the tools and help to effectively treat the disease.

Intermountain Healthcare and SelectHealth calculated the total estimated savings for patients receiving telehealth-based care for 10 common diagnoses as compared to other settings, including the emergency department, urgent care and primary care. The results indicate that the total cost (claim and patient payment) of telehealth-based services was on average $323 less than for urgent care settings, $378 less than for primary care and $3,152 less than an emergency department visit.

Source: https://www.npr.org/sections/thesalt/2018/03/05/589286575/this-chef-lost-50-pounds-and-reversed-pre-diabetes-with-a-digital-program

2. Spectrum Health/Priority Health Plan: MedNow Telehealth Program

Spectrum Health and its subsidiary Priority Health Plan rolled out its MedNow telehealth program in 2014. The program has succeeded in improving patient care and reducing costs. The program has allowed Spectrum to avoid 11,253 emergency room trips and 269 hospital transfers in just three years. A telehealth visit utilizing Mednow cost patients $42, while a visit to the emergency room can exceed $1,000. In the same time frame, Spectrum's MedNow has conducted nearly 50,000 digital patient visits, 30,755 visits for acute care and 19,033 for specialty appointments. MedNow has also helped patients avoid 944,023 miles of unnecessary traveling to see a provider, saving patients time and money by providing convenient access to care on a patient's own terms.

Furthering its mission to reduce the cost of care, Priority Health utilizes an online tool to estimate patients' out-of-pocket costs. The cost estimator has helped patients avoid more than $6 million in costs in 2017 alone by using pricing information and opting for outpatient treatments.

Source: https://www.digitalcommerce360.com/2018/05/18/telehealh-saves-a-big-health-system-4-million-in-just-three-years/
http://www.crainsdetroit.com/article/20180401/news/656771/health-insurers-push-patients-away-from-hospitals

3. Kaiser Permanente: Geriatric Care at Home as Alternative to Hospital

Geriatric patients in Kaiser's Mid-Atlantic region who need specialized care are offered a choice of being admitted to the hospital or being treated at home by a geriatric specialist able to administer treatments

such as intravenous diuretics and respiratory therapy. This technology combines affordability, accuracy of treatment and convenience. Patients who have gone through this program have spent, on average, two fewer days in hospitals or emergency departments than patients who were hospitalized to start.

More broadly, after implementing a robust telemedicine program throughout its health care system, Kaiser Permanente now provides more than half of its patient interactions virtually: In 2016, more than 55 million interactions with physicians were conducted virtually. This number is expected to grow. Patients receive convenient care for minor ailments or receive test results with the goal of keeping members healthy and encouraging preventive virtual visits. Implementation of telehealth services has allowed Kaiser Permanente to use specialists more effectively, helping save lives. Kaiser Permanente emergency centers have access to telestroke neurologists at all times thanks to telehealth technology; this has allowed emergency personnel to administer life-saving medication more quickly, helping cut down on mortality rates, according to the journal *Stroke*.

Source: http://www.modernhealthcare.com/article/20170421/NEWS/170429950/-kaiser-permanente-chief-says-members-are-flocking-to-virtual-visits
https://www.sacbee.com/news/local/health-and-medicine/article213457394.html

4. Presbyterian Healthcare: SmartExam

Presbyterian Healthcare implemented SmartExam to allow patients to receive medical advice and care virtually. Presbyterian also introduced a Spanish language feature which will eliminate barriers to care in many New Mexico communities. Consumers report high satisfaction with the platform. Six million individuals nationwide are utilizing SmartExam to receive virtual health care, with 90 percent of patients saying they would use SmartExam again and 88 percent of providers reporting high satisfaction.

Source: https://markets.businessinsider.com/news/stocks/presbyterian-healthcare-and-providence-health-services-launch-statewide-implementations-of-bright-md-virtual-care-solution-1015631544

5. **UPMC Health Plan: Anywhere Care**

In November 2016, UPMC Health Plan launched a virtual urgent care service called UPMC AnywhereCare. Patients anywhere in the U.S. can access qualified urgent care providers 24/7 through a smartphone, tablet or computer. Since the inception of the program, UPMC AnywhereCare has seen over 43,000 enrollments with over 13,000 patients completing a virtual urgent care visit. Over 6,000 patient ratings have rated patient satisfaction of their virtual experience as 4.9 out of 5.0 stars. As awareness of these services increases, monthly volumes exceed their previous year monthly volumes by over 100%, and in many cases, well over 200%. The use of the virtual urgent care service has saved UPMC Health Plan nearly $400,000 by avoiding unplanned care visits to the emergency room, urgent care, and physician offices.

UPMC Health Plan is currently piloting scheduled virtual visits for post discharge and post surgical follow-up patients. In late 2018, there are plans to implement telehealth into outpatient IV antibiotic therapy home health visits through the use of Bluetooth compatible peripherals and virtual patient-to-provider interactions. These visits are expected to decrease readmissions and unplanned care leading to a projected medical expense savings of over $1,000,000 across 4 years.

Attachment 2
State Consumer Protections Apply to Telehealth-Based Services

A large body of existing state laws guards against the misuse or inappropriate use of health care services. Along with federal protections addressing privacy and security risk, internal and external review of health plan decisions, and federal anti-kickback requirements, these state laws protect consumers from overuse or misuse whether patients are seeking in-person health care services or telehealth services. CMS should look first to existing state and federal laws and regulatory structures as it considers the need for any additional protections.

States have established legal protections intended to ensure adequate access to care, eliminate incompetent providers, prevent unscrupulous use of healthcare services, and provide patients with avenues for grievances and appeals. As summarized below, state consumer protections are grounded in laws and regulations on:

- Provider licensing and certification
- Provider networks
- Prescribing
- Informed consent
- Grievance and appeals rights
- Reimbursement parity

Provider Licensing and Certification. All states license medical providers to protect residents from unprofessional, incompetent, or improper practice of medicine. That authority comes from each state's Medical Practice Act. Those laws define the requirements for practicing medicine within the state and give authority to enforce the Act's provisions to a medical board.

Half of the states have adopted an Interstate Medical Licensure Compact (IMLC) which provides for an expedited medical licensure process allowing physicians to become licensed in multiple states.[1] While it does not specifically address telehealth, increasing access to telehealth services was one of the factors in its development. The IMLC is an agreement among 24 states and 1 territory and the 31 Medical and Osteopathic Boards in those states and territory. The process for adopting an interstate license begins with the physicians' existing information previously submitted in their state of principal license. Under that process, a physician's information is verified and a fresh background check is completed. Once qualified the physician can select any number of IMLC states from which they desire to practice.[2]

Similar compacts have been developed for other providers. For example, under the Nurse Licensure Compact (NLC) and the more recent "enhanced" compact (eNLC), the nurse license from one state is recognized in Compact member states. As of January 2018, twenty-nine states have adopted eNLC standards.[3]

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[1] State Licensure Compact Legislation (as of May 2018), *American Telemedicine Association*, https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/State%20Policy%20Resource%20Center/State_Licensure_Matrix_2018.pdf
[2] See the Interstate Medical Licensure Compact at http://www.imlcc.org/.
[3] See Licensure Compacts, National Council of State Boards of Nursing, https://www.ncsbn.org/compacts.htm; and States Implement Health Reform; Right to Health Insurance Appeals Process, *National Conference of State Legislatures (NCSL)*, February 2011, http://www.ncsl.org/documents/health/hrhealthinsurapp.pdf.

Cross-state compacts recognize that the state of practice is the state where the patient, not the provider, is located. The AMA supports the use of cross-state compacts because they can ease the use of telemedicine while also allowing for sharing disciplinary and investigative information across state lines.[4]

Provider Networks. State network adequacy laws provide states with the ability to analyze, monitor and enforce access standards. They apply to plans whether or not they provide some services through telehealth providers and protect against the substitution of telehealth providers for an adequate network. There is variation, however, on which provider and insurer types the standards apply to, how the qualitative standards are defined, the timing and frequency of the reviews, the extent to which regulators can require plans to make changes, and the transparency of plan submissions.

Prescribing. State laws and regulations define if and how providers including telehealth providers can prescribe medicines. State Medical Board and Pharmacy Board regulations require the establishment of a patient-provider relationship in order for physicians to write a prescription and for pharmacists to fill a prescription.

Recently, states have begun formulating policy on when and if telehealth can be used to establish a patient-provider relationship in relation to prescribing. Most states also explicitly prohibit the prescribing or dispensing of a prescription based solely on an Internet/online questionnaire, consultation, phone call or email.[5]

States rules on prescribing vary but seem to be in agreement that providers should be able to prescribe via a telehealth visit, provided that the provider-patient relationship has been established.[6] There is a federal floor for requirements and limitations established by the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (P.L. 110–425). The law generally prohibits the dispensing of controlled substances through the Internet without a valid prescription, which requires the prescriber to have conducted at least one in-person medical evaluation of the patient. It exempts telehealth providers from this requirement under a limited set of circumstances. This includes situations when the patient's originating site is a Drug Enforcement Administration (DEA)-registered clinic or hospital (21 CFR Part 1300).

Informed Consent. As of May 2018, thirty states and the District of Columbia had informed consent requirements in their statutes, administrative code, or Medicaid policies.[7] With respect to telehealth, informed consent generally refers to providers obtaining permission from a patient to use telehealth as a service delivery method. This would include, for example, understanding the nature and limitations of telehealth including the technology involved. The scope of these requirements vary and may apply to all telehealth encounters, a specific specialty or only to its Medicaid program. More than half (18) of these requirements apply to all telehealth encounters and involve oral and/or written consent. Details of the specific policies in these thirty-one jurisdictions are included in the attached Table 1.

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[4] Issue Brief: Interstate Medical Licensure Compact, *American Medical Association*, 2017, https://www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/fsmb-interstate-medical-licensure-compact-issue-brief.pdf.
[5] See National Consortium of Telehealth Providers, Telehealth and Prescribing web site, https://www.telehealthresourcecenter.org/toolbox-module/telehealth-and-prescribing.
[6] Medicare Payment Advisory Commission, March 2018 Report to Congress, Medicare Payment Policy, Chapter 16: Mandated report: Telehealth services and the Medicare Program, http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_sec.pdf?sfvrsn=0.
[7] Center for Connected Health Policy: The National Telehealth Policy Resource Center. May 2018. *State telehealth laws and Medicaid program policies: A comprehensive scan of the 50 states and the District of Columbia.* Sacramento, CA: Retrieved from: http://www.cchpca.org/sites/default/files/resources/50%20STATE%20FULL%20PDF%20SPRING%202018%20-%20PASSWORD.pdf.

Grievance and Appeals Rights. Prior to the ACA, almost all states required some state-regulated health insurance plans to provide plan enrollees with a process for reviewing plan decisions. The applicability among health plans and the specific requirements of those laws, however, differed widely among states. In addition, self-insured health plans were not subject to any of those state laws. Beginning in 2010, the ACA established minimum requirements for state internal and external appeals processes that apply broadly to plans in the individual and group markets for health insurance – except for grandfathered health plans. As a result, under today's federal and state appeals requirements, beneficiaries can challenge decisions by a health plan to deny payment for medical care, deny that a service or procedure is medically necessary, or deny a person's eligibility for a benefit or service. A person can also appeal a denial based on a conclusion that the service is experimental, or a finding that the person is not eligible for coverage based on a pre-existing condition. States may go beyond those federal minimum standards, applying more stringent appeals processes or additional levels of review and many of them do so.[8]

Reimbursement. As of July 2017, 35 states and the District of Columbia have telehealth parity laws. Such laws require private insurers to cover or pay for telehealth services on a basis equal to in-person health care services to some degree. These laws ensure that there are not financial disincentives for using telehealth services with the goal of assuring adequate access for consumers needing those services. In most of the states with parity laws, the laws offer coverage parity to beneficiaries – requiring insurers to cover the same services delivered through telehealth as are covered in-person. This is a broader approach than in Medicare, which prescribes a defined set of telehealth services that it will cover and approves additional services on a code-by-code basis. There is broad variation in these parity laws with states' laws differing based on factors including service coverage, payment methodology, eligible patients and providers, and authorized technologies. Other reimbursement parity laws have language that telehealth must meet the same standard of care as in-person care, which would also provide some discretion to private insurers to limit the use of telehealth.

Not all of these states that have coverage parity have laws that mandate reimbursement. Some states, such as Virginia, have laws that require reimbursement to be the same as for in-person services. Tennessee requires that private payers provide coverage for telehealth services on the same basis and at least at the same rate as in-person services regardless of location. Other states have language in the telehealth parity laws that provide flexibility to insurers to set reimbursement for these services based on the "contract terms and conditions."[9]

[8] States Implement Health Reform; Right to Health Insurance Appeals Process, NCSL, February 2011
[9] Center for Connected Health Policy, May 2018.

Table 1: Informed Consent Requirements by State and District of Columbia, 2018

State	Nature of Requirement	Applicability: All telehealth encounters, a specific specialty, or only Medicaid	Source
Alabama	Written informed consent is required prior to an initial telemedicine service.	Medicaid only	Medicaid provider manual
Arizona	Written or oral consent required prior to an initial telemedicine service.	All telehealth encounters, additional requirements for Medicaid.	AZ statute
California	Written or oral consent required prior to an initial telemedicine service. Applies to originating site (location of patient).	All telehealth encounters: additional requirements for occupation therapy and behavioral sciences, and Medicaid program	CA statute and Med-Cal provider manual.
Colorado	Providers required to give first-time patients a written statement that incudes these rights: (1) patient may refuse telemedicine services (without loss or withdrawal of treatment), (2) confidentiality is assured, and (3) patient has access to all medical information from the services.	All telehealth encounters, additional requirements for Medicaid	CO statute and Medicaid guidance.
Connecticut	Providers required to provide information and obtain consent. Information includes information on patient treatment and limitation of the telehealth platform.	All telehealth encounters	CT statute
District of Columbia	Patient consent is required and must be documented	All telehealth encounters, additional Medicaid requirement.	DC regulations
Delaware	Informed consent is required	Statute is specialty specific: Mental Health Counseling, Chemical Dependency Counseling, or Marriage and Family Therapy, additional Medicaid requirements	DE statute

State	Nature of Requirement	Applicability: All telehealth encounters, a specific specialty, or only Medicaid	Source
Georgia	Referring provider must obtain prior written consent	Medicaid only	Medicaid guidance
Idaho	Patient consent is required	All telehealth encounters, additional Medicaid requirement.	ID statute
Indiana	A separate additional consent for telehealth may not be required (if already obtained by a health care provider)	All telehealth encounters, additional Medicaid requirement.	IN statute and Medicaid guidance
Kansas	Written consent required for telehealth home services	Medicaid only, applies only to home health	Medicaid provider manual
Kentucky	Provider that delivers or facilitates the telehealth service must obtain informed consent.	Statute is specialty specific: physicians, chiropractors, nurses, dentists, dieticians, pharmacist, psychologist, occupational therapists, behavioral analysts, ophthalmologists, physical therapists, speech language pathologists or audiologists, social workers, and marriage/family therapists. Medicaid has additional requirements	KY statute and regulations.
Louisiana	Provider must provide information about telehealth and give patient the option to decline to receive telemedicine services.	All telehealth encounters	LA statute
Maine	Provider must provide written educational information (specifies content) and document consent for remote patient monitoring.	Medicaid only	Medicaid guidance
Maryland	Originating site must obtain consent, physician must document consent (except when providing interpretive services). Specifies content	All telehealth encounters, additional Medicaid requirement.	MD statute and regulations.

State	Nature of Requirement	Applicability: All telehealth encounters, a specific specialty, or only Medicaid	Source
Mississippi	Provider should obtain the patient's consent before treatment	All telehealth encounters	MS statute
Missouri	Patient consent required for certain services and specialties	Service and specialty specific. Required for services related to pregnancy and collaborative care arrangements, asynchronous store-and-forward technology, and a school as a originating site. Advanced Practice Registered Nurses must obtain consent.	MO statute and regulations.
Nebraska	Written consent is required prior to service.	All telehealth encounters, additional Medicaid requirement.	NE statute and Medicaid guidance.
New Jersey	Informed consent is required for telepsychiatry	Medicaid only	Medicaid guidance (newsletter)
New York	Informed consent is required for telepsychiatry	Medicaid only	Medicaid regulations.
Ohio	Informed consent is required and must be documented in patient's record. Additional requirement of speech language pathology to inform patients of telehealth limitations.	All telehealth encounters, additional Medicaid requirement.	OH statute
Pennsylvania	Informed consent is required for telepsych	Medicaid only	Medicaid guidance (bulletin)
Rhode Island	Informed consent required in limited situations.	Specific to patient-physician e-mail and other text-based communications.	RI policy
Tennessee	Consent must be documented in record and given the option to request an in-person assessment.	Medicaid only	TN policy
Texas	Consent required prior to service. (if originating site is school, parent or legal guardian consent must be obtained).	All telehealth encounters, additional Medicaid requirement.	TX statute and Medicaid guidance

State	Nature of Requirement	Applicability: All telehealth encounters, a specific specialty, or only Medicaid	Source
Vermont	Written or oral consent required prior to an initial telemedicine service.	All telehealth encounters, additional requirements for tele-ophthalmology and tele-dermatology.	VT statute
Virginia	Informed consent must be obtained and maintained	All telehealth encounters	VA guidance
Washington	Consent must be obtained for store-and-forward	Medicaid only	Medicaid provider manual
West Virginia	Must obtain consent	All telehealth encounters, additional Medicaid requirement.	WV statute and Medicaid guidance.
Wisconsin	Informed consent required	All telehealth encounters; additional Medicaid requirement	WV statute and Medicaid guidance.
Wyoming	Written or oral consent required	All telehealth encounters; additional Medicaid requirement	WY regulations and Medicaid guidance.

Source: Analysis of report data from Center for Connected Health Policy 2018 report.