AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

May 28, 2020

Demetrios Kouzoukas
Principal Deputy Administrator & Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Risk Adjustment for Audio-Only Telehealth Services

Dear Principal Deputy Administrator Kouzoukas:

America's Physician Groups (APG) applauds the many actions you have taken in response to the COVID-19 public health emergency to expand flexibilities for healthcare providers so that they may extend care to patients. We also commend CMS for allowing Medicare Advantage (MA) plans to take into account diagnoses from telehealth encounters with both audio and video components for risk adjustment purposes. There is an additional issue surrounding telehealth services that we believe desperately needs the agency's attention. We are urging the Centers for Medicare & Medicaid Services (CMS) to provide additional flexibility to count diagnoses obtained from audio-only telehealth services for risk adjustment purposes under the MA program during the ongoing COVID-19 public health emergency. We also understand CMS's concern for potential fraud in using audio-only for risk adjustment. However we believe that many of the guard rails that have been proposed by CMS will simply hamper physicians' ability to adequately care for their seniors without adding any additional benefit.

About America's Physician Groups

APG is a national professional association representing over 300 physician groups that employ or contract with approximately 195,000 physicians that provide care to nearly 45 million patients. Our tagline, "Taking Responsibility for America's Health," represents our members' vision to move from the antiquated fee-for-service (FFS) reimbursement system to a value-based system where physician groups are accountable for the cost and quality of care. Our preferred model of capitated, delegated, and coordinated care eliminates incentives for waste associated with FFS reimbursement. APG member organizations are working diligently to rise to the challenge presented by the COVID-19 pandemic. We are focused on the transition of most patient visits to telehealth as a best practice in slowing the spread of the virus and keeping patients safe.

Summary of APG's Recommendation

- **Diagnoses obtained from audio-only telehealth services should be eligible for risk adjustment**
- **Guardrails offered by CMS present obstacles for physicians in providing care that must be addressed**

Many patients, including numerous seniors, reside in rural areas of the country where they struggle to access the technology or broadband internet service that may be available in physicians' offices. In addition, it is quite common for seniors to express difficulty in navigating the video technology included on video equipped smartphones and similar devices. Barriers that inhibit patient participation in telehealth or add additional burdons to already strained organizations will prevent patients from receiving necessary care. Providers have had to adapt to the reality of the COVID-19 pandemic by transitioning up to 70 percent of care to telehealth, while some APG member organizations report that up to 80 percent of adult primary care telehealth services are conducted using audio-only technology.

We recognize the agency's concern surrounding the ability of providers to adequately confirm diagnoses or reconfirm comorbidities for patients through audio-only services. Physicians who care for patients within our member organizations have made it clear that diagnoses can be made and sufficiently evaluated without the need for a physical exam, making the requirement of video to qualify the use of a telehealth service for risk-adjustment unnecessary. The verbal assessment of symptoms, supplemented by a review of any necessary diagnostic information in the medical record such as labs, along with patient-reported vitals such as weight, blood pressure, and heart rate, all allow for physicians to adequately assess most chronic and acute conditions and collaborate with the patient on a plan using audio-only services. In these instances, the video component of telehealth services does not offer any additional benefit over audio-only technology. That said, if audio-only services are not adequate for an appropriate evaluation of a patient's new or existing conditions, physicians will ensure the appropriate in person or video-based technology service is provided to clinically evaluate the patient adequately.

We are also aware that CMS has proposed potential guardrails in expanding risk adjustment encounters to include audio-only telehealth. While we approve of some of the proposed guardrails, there are several that we believe CMS should consider revising or eliminating.

Below are our recommendations:

1. **Restricted to Only Established Patients**

We have identified two major issues with this guardrail from the agency, **the first being that established patients versus new patients is an arbitrary differentiation**. Physicians are delegated for MA patients and as a result are responsible for their health care needs regardless of when a patient may first contact them. Some patients are experiencing new

symptoms/concerns during this pandemic and since open enrollment as other patients' pre-existing conditions worsen, so the need for physicians to be available to prevent or slow progression is paramount as well as the ability to receive credit in recognition of the patients' elevated risk.

Secondly, there is administrative complexity given the recent enforcement relaxation of the "established patient" requirement during the public health emergency. Given that plans typically rely on the CPT code to determine if a patient is new or established and the six allowable E/M telephone codes don't make this distinction, determining a patient's status is difficult. **If CMS moves forward with implementing this guardrail, we request that the agency provides guidance to physicians and other health care providers on how to indicate whether the patient is new or established**, such as ,establishing a new modifier for telephonic CPT codes or requiring plans to review patient claim history.

2. **Limited to Pre-existing Conditions Previously Submitted for Risk-adjustment Purposes**

Physicians are able to easily make new diagnoses using audio-only telehealth services. One of the purposes of risk adjustment is to identify those patients with the highest risk factors and care for them. Making new diagnoses and developing treatment plans via an audio-only service should be at the clinical discretion of the medical service provider. As an example, during the PHE, many people have become stressed, fearful and feeling isolated. These new mental health conditions can be diagnosed via standardized assessments and addressed during audio-only visits. Additionally, patients who have been self monitoring for borderline elevated blood pressure can be diagnosed and managed by an audio-only visit without the need or any added benefit with video should their conditions worsen.

3. **Limited to Visits Initiated by Patients unless the Plan Has Requested the Visit to Share Specific Lab Results**

While we appreciate CMS' concerns surrounding this issue, we would point out that **limiting visits to those initiated by patients contradicts the goals of population health management.** Some of our member organizations report that they have been able to identify those patients with the highest risk for complications from COVID-19 infection through their Electronic Health Records (EMR) and performed outreach. We have heard overwhelming and sadly frequent reports of patients expressing gratitude because they were wary of an in-office visit and didn't think they could get help any other way. Our providers discovered patients unable to access food and medicines as well as others experiencing worsening of their chronic heart failure and Chronic Obstructive Lung Disease (COPD) and depression. If their provider had not reached out, the patient themselves never would have until they ended up in the ER, or worse. Physicians are able to assess these kinds of conditions over the phone and through audio-only telehealth, can provide for the general care of the patient, observing other symptoms and issues and linking them to care with specialists and providers. Limiting visits only to those requested by patients does not take into account that many patients are not calling into providers because they are scared to physically visits offices due to the pandemic and are either unaware of the extent of telemedicine, or do not own smartphones allowing them to qualify for care.

We recommend that the permissions noted for Virtual Check Ins within the CMS COVID Dear Clinician Letter be used to define patient initiation. Specifically, we request that the guardrail read, "Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation." Similarly, plans should be able to outreach to members to provide information on the coverage of telehealth services.

4. **Diagnoses Must Be Captured by Two Providers from Different Practices**

APG recognizes the importance of accurate and truthful reporting for CMS. Despite that fact, this guardrail presents challenges for provider organizations. Many of our members collectively manage their organizations as a single practice, despite having different regional practices. **Their organizational structures therefore make it difficult to achieve many of the standards included within this guardrail** such as the standard regarding time and distance. Adding in other factors such as limited health information exchanges, creates another chance for failure. CMS must also take into account the issues presented by differences in access across geographical regions. Due to COVID-19, some locales may have issues with things such as access to primary care as compared to others. This would create a problem for providers in other regions to find additional physicians to see their patients as other locales are experiencing shortages of their own. This may also place an undue burden on the patient to see a second provider solely to enable HCC coding.

5. **Supported by Additional Documentation in Medical Record Beyond the Diagnosis Itself**

We ask that CMS **provide greater clarification on what this guardrail could potentially entail, specifically as it pertains to the degree of documentation required and what providers may be required to submit to the agency beyond what is currently required**. As physicians scramble to adjust their practices to a new paradigm during the public health emergency, any additional administrative burden must be avoided. Many diagnoses do not require any other documentation beyond the current note, such as the behavioral health issues noted earlier.

6. **Diagnoses Captured From Audio-only Should Be Tied to Specified Lab Test Results**

Similar to our other recommendations, **we would ask that CMS treat diagnosis codes from audio-only telehealth services with parity when compared to diagnosis codes from other services**. Diagnoses from non-audio-only services are not limited to specific lab tests and as such, audio-only telehealth services should not be held to this standard either. Re-capture of amputation status, or management of a seizure disorder or assessment of COPD, for example, do not require lab tests**. We ask that this guardrail be eliminated.**

7. **Plans Must Self-Audit Using Independent Auditor 100% of Diagnoses Captured from Audio-only and Report Audit Results Back to CMS**

This guardrail should be revised in order to ensure that CMS' compliance program requirements are in alignment with any current documentation and audit standards while utilizing the existing attestation mechanism. Audio-only telehealth services can be added to existing audit programs without needing to create new, separate programs that will create added

work and administrative burden for practices at a time when many practices are already stretched thin.

8. <u>CMS would impose a cap at plan level on how much the diagnoses can increase plans average risk score from the previous year</u>

In light of the other guardrails proposed by CMS, and the current compliance requirements in MA, **we find this guardrail to be duplicative and unnecessary. Instead, simply establishing a cap on the contribution that telephone codes could present by plans will suffice**.

Thank you for your attention to this issue. We look forward to continuing to work with you throughout this process. Please feel free to contact Valinda Rutledge, Senior Vice President, Federal Affairs, (vrutledge@apg.org) if you have any questions or if America's Physician Groups can provide any assistance as you consider these issues.

Sincerely,

Donald H. Crane
President and CEO
America's Physician Groups