March 13, 2020

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

Re: Request to Immediate Lift Once a Month Restrictions on Telehealth in Nursing Facilities

Dear Administrator Verma:

AMDA-The Society for Post-Acute and Long-Term Care Services (AMDA) is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants and other practitioners working in post-acute and long-term care (PALTC) settings. AMDA’s 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other similar settings.

Our clinicians are on the front lines of response to the COVID-19 pandemic and working closely with nursing facilities across the country to mitigate the spread of this virus. PALTC based clinicians are a high-risk group of necessary staff that could transmit the virus from facility to facility since an average clinician goes to multiple facilities. By lifting telehealth restrictions on nursing facilities, it will greatly help to reduce this risk of transmission by clinicians and enable safe social distancing while still providing care to residents. The situation in Washington state spread quickly and it is possible that affected homes were serviced by the same clinicians.

Many of these clinicians see patients in multiple facilities that can be far apart geographically. Unlike visitors whose access can be restricted, our facilities need clinicians there to take care of patients for both COVID-19 and non-COVID-19 related changes in condition. If we can prevent hospitalizations and clinic visits with our care, that will also help reduce transmission.

Therefore, we agree with the March 9, 2020, CMS Announcement titled “Medicare Benefits in Medicare are a Lifeline for Patients During Coronavirus Outbreak”. Likewise, we support Congressional action that waived restrictions for coronavirus screening in its emergency funding legislation.
However, neither this legislation, nor the announcement allows for use of telehealth in nursing facilities more than once every month as was confirmed by an e-mail communication with CMS officials on March 11, 2020.

We are writing to request that CMS immediately lift the restriction during this pandemic. Enforcing this policy will put lives at risk and it is important for clinicians to reduce unnecessary exposures and limit the number of times that they come into contact with any COVID-19 cases and/or the buildings in which these cases are occurring. Our organization has requested that this restriction be lifted on previous occasions including a letter from November 20, 2019 and request your prompt attention to this issue.

**Rationale for Rescinding Once a Month Policy as Submitted in Previous Letters**

We continue to urge CMS to rescind the limitation of one telehealth subsequent nursing facility care visit every 30 days reported by CPT Codes 99307 through 99310. We are concerned that this limitation stifles innovation and use of telehealth in the PALTC setting, which is vital to the continuum of care and where many seriously and chronically ill Medicare and Medicaid beneficiaries receive care. Demonstration projects, such as CMS’ Initiative to Reduce Unnecessary Hospitalization’s Among Long-Stay Nursing the PALTC setting, which is vital to the continuum of care and where many seriously and chronically ill Medicare and Medicaid beneficiaries receive care.

We believe these and other similar demonstrations should be adopted in the Medicare program. Rather than using an arbitrary limitation on visits, CMS should allow for the use of these services when they are medically necessary and regardless of geographic location, as is the case for face-to-face visits in the nursing home setting.

We further recommend that CMS direct its contractors to monitor the utilization of these telehealth services to ensure they are not overutilized. If widespread evidence of overutilization becomes apparent, then CMS should reassess utilization of the code to ensure appropriate care is being delivered and to determine appropriate action against those who submit these codes without medical necessity. But there is no reason to expect that these services would be overutilized and create an atmosphere of scrutiny that will discourage the utilization of this valuable technology that can help prevent hospitalization and rehospitalization by providing a more expedient practitioner evaluation and workup.

However, until evidence of overutilization is obtained, we believe an arbitrary and very low limit could hinder access to appropriate care under the telehealth benefit, especially in underserved areas. For a busy PA/LTC practitioner, if a single patient in a single nursing home 40 minutes’ driving distance away has a change of condition, it may be unrealistic to make the trip and lose several hours of otherwise potentially productive clinical time to see a single patient. Further, many transfers occur at night and on weekends when clinicians may be unavailable or may not have the necessary time or capacity to evaluate a patient enough to determine whether they should be sent to the hospital. In such instances, a telehealth visit may well obviate the need for an emergency room visit. Allowing for such visits anytime there is a significant change, makes intuitive sense, and may allow for more timely practitioner assessments of patients who need them.
While previous reasoning that because of the potential acuity and complexity of SNF inpatients, a restriction on the frequency of such visits may have made sense a decade ago, it’s simply not realistic in today’s era of value-based medicine, which CMS has embraced. We remain committed to ensuring that these patients continue to receive in-person, hands-on visits as appropriate to manage their care, as well as regulatory visits. We continue to agree that patients in SNFs/NFs are complex and need to be seen by trained and qualified clinicians, but we believe previous concerns about overutilization of telehealth are simply outdated. Current research shows that telehealth allows patients to be monitored more closely and allows the clinician to evaluate and understand when a patient should be seen due to a change of condition. Without telehealth, these patients may not be seen at all, and end up in the emergency room as result. Research on the use of telemedicine for change in condition in the nursing home has demonstrated its potential to deliver high quality care, reducing preventable ED visits and hospitalization.1

Value-based models on quality reporting and outcomes and are testing new ways of delivering telehealth in a way that is more efficient and benefits patients. As the systems move from a siloed approach to a more integrated and aligned health system, it makes no sense to issue arbitrary limitations on one sector of healthcare that do not apply to all others.

We strongly urge CMS to allow for more frequent reassessment of patients with a change of condition that is highly likely to result in a trip to the emergency department or a hospitalization. One visit a month is woefully inadequate even for a clinician to provide telehealth evaluation and then reassess whether the ordered intervention has been successful. This system requires flexibility to allow practices use of innovative methods to deliver patient care that achieves the stated desired outcomes. We look forward to working with you to resolve this technical but important issue. If you have questions on this letter or require a meeting, please contact Alex Bardakh at abardakh@paltc.org or (410) 992-3132.

Sincerely,

Arif Nazir, MD, FACP, CMD, AGSF
President