November 20, 2019

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: Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019 (CMS-1693-P)

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 (PA/LTC) 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.

We are following up on our previous comments on the CY 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule with specific input on the telehealth provisions of the final rule.

The Society was disappointed that CMS decided not to propose to remove the frequency limitation for subsequent nursing facility care services in CY 2019. 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 PA/LTC 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 Home Residents, have utilized telehealth, have shown positive results, do not limit the frequency of use of telemedicine on a particular resident, nor are Medicare telehealth originating site payments restricted by geographic location.
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 a 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