ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

May 20, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Re: Medicare Advantage Risk-Adjustment for Audio-only Encounters is Essential to Capture Vital Information and Maintain Market and Provider Stability

Dear Administrator Verma,

The Alliance of Community Health Plans (ACHP) values your efforts to ensure providers and payers have the necessary flexibilities to continue providing high-quality coverage and care throughout this public health emergency. As you know, ACHP members embody the distinctive payer-provider aligned model, delivering high-quality, coordinated care. Our non-profit, community-based member organizations continue to use value-based programs and benefit designs to confront the pandemic, reach enrollees and members of their communities.

The ability of ACHP members to rapidly shift to near-total telehealth use for care delivery is a testament to your quick actions and the industry's preparation for increased adoption of virtual care. ACHP appreciates the ability to utilize face-to-face telehealth encounters for Medicare Advantage (MA) risk-adjustment and we continue to strongly encourage CMS to expand this ability to audio-only encounters under certain circumstances. ACHP member plans have seen audio-only modalities remain a popular choice for MA beneficiaries and member plans. For example, Security Health Plan and Kaiser Permanente experience in April was that 75% and 85% of their telehealth visits, respectively, were audio-only.

With the pandemic's disruption to health care utilization, there will be long-term effects on patient health and outcomes resulting from delaying in-person care. Continuing to expand the use of smart phones and other audio-video capable technology helps mitigate the effects of this disruption and provide routine and necessary care during this health emergency. However, there are specific sectors of the population that either lacks access to this technology or are uncomfortable with its use. The ability to use audio-only technology gives patients and providers peace of mind and allowing plans to use the encounters for MA risk-adjustment will help the industry appropriately prepare for the influx of currently backlogged, and potentially sicker, patients. ACHP seeks to ensure an appropriate and safe path forward for the patients receiving care via audio-only technology.

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We appreciate CMS considering expanding risk adjustment encounters to include audio-only telehealth by identifying potential guardrails. ACHP and our members agree that certain protections are needed. However, ACHP is concerned with several elements raised by CMS staff and we offer the following recommendations:

1. Restricted diagnoses from audio-only to those that result from one of 6 E&M codes paid for by traditional Medicare fee-for-service.
   ACHP supports including this guardrail should CMS approve a policy for allowing audio-only telehealth visit risk adjustment data.

2. Restricted to only established patients.
   ACHP is supportive of this approach while noting the administrative complexity given the recent enforcement relaxation of the "established patient" requirement during the pandemic. Importantly, determining a patient's status is difficult given that plans typically rely on the CPT code and the six allowable E/M telephone codes do not differentiate "new" versus "established." To implement this guardrail, we request CMS provide guidance to physicians and other health care providers on how to indicate whether the patient is new or established, such as requiring providers to note in documentation, establishing a new modifier for telephonic CPT codes or requiring plans to review patient claim history.

3. Limited to pre-existing conditions previously submitted for risk-adjustment purposes.
   A blanket limitation to pre-existing conditions, without exception, will significantly impact providers abilities to properly account for patients with diagnoses that can be confirmed by lab tests, connected to other test results or if the patient is actively taking medication. For example, this limitation would exclude diagnosis of certain mental/behavioral health conditions. ACHP strongly recommends that CMS offer an exception to allow for new diagnoses of mental/behavioral health conditions or other new diagnoses that can be accurately confirmed with testing, or other comparable results or prescriptions.

4. Limited to visits initiated by patients unless the plan has requested the visit to share specific lab results.
   ACHP understands CMS' concern that providers or plans may unnecessarily contact members. However, we have two concerns with this proposed guardrail. First, it will be difficult to determine whether the audio-only visit was initiated by the patient or practitioner. Second, health plans would need additional guidance from CMS regarding how a physician should demonstrate, and a plan determine with reasonable documentation, whether the physician, plan or patient "prompted" the audio-only visit. For example, such guidance could be requiring physicians to document initiation or restrict plan and provider outreach solely for medically necessary services. ACHP encourages CMS to replace this with: "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 contact members to provide information on the coverage of telehealth services.

5. Diagnoses must be captured by two providers from different practices.
   Capturing the diagnosis by two providers from different practices is a particularly challenging notion. First, in areas with limited access to providers or high provider consolidation, patients may not have access to more than one physician practice. Second, CMS would need to provide a sufficiently broad definition of "practice" to avoid singling out health plans such as Kaiser Permanente, a fully integrated system. Third, while some chronic conditions require the care of multiple specialists, others can be effectively monitored and treated by the patient's primary care physician. Lastly, a health plan may not know whether two physicians are within the same practice in real-time.

6. Supported by additional documentation in medical record beyond the diagnosis itself.
   ACHP notes that the burden of this guardrail will likely fall to providers who would need specific documentation guidelines and training which would need to be defined and agreed to. Practices that have point-of-care alert and documentation tools would incur the burden of adjusting their workflows to the new documentation requirements. Therefore, ACHP encourages CMS to allow providers to maintain current documentation standards.

7. Diagnoses captured from audio-only should be tied to specified lab test results.
   ACHP recommends that any diagnostic test or lab be allowed as well as other indicia such as standardized assessments and prescriptions for those types of conditions that do not require a lab/radiology/pathology test to be diagnosed. In addition, limiting the risk adjustment data to diagnoses tied to specific lab tests fails to account for continuous management of a disease and undermines the necessity for capturing mental and behavioral health diagnoses. ACHP recommends CMS include all forms of diagnostic testing, assessments and prescriptions.

8. Plans must self-audit using independent auditor 100% of diagnoses captured from audio-only and report audit results back to CMS.
   ACHP encourages CMS to align documentation and audit standards with existing CMS compliance program requirements and utilize its existing attestation mechanism. For example, CMS can add audio-only encounters to RADV audits or regular contract reviews. Auditing 100% of diagnoses is not practical and exceeds the regulatory requirement which specifies that MA plans "will be required to submit a sample of medical records for the validation of risk adjustment data." 42 CFR 422.310(e).

   In addition, CMS regulations require that plans certify to the accuracy, completeness and truthfulness of risk adjustment data "based on best knowledge, information, and belief." 42 CFR 422.504(l)(2). Requiring a higher standard for data submitted as a result of an audio-only encounter exceeds CMS' authority under the existing regulation and, as proposed, is similarly unworkable.

9. <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, ACHP considers the cap unnecessary. Should CMS determine that some element of this guardrail be maintained, ACHP recommends that CMS only cap how much change the telephonic acquired codes could contribute.

ACHP looks forward to working with CMS to develop and refine necessary guardrails to allow audio-only telehealth encounters to be used in MA risk adjustment. We thank you for considering our comments and recommendations. If you have questions or require additional information, please contact Michael Bagel, ACHP Director of Public Policy, at mbagel@achp.org or (202) 897-6121.

Stay safe and well.

Regards,

Ceci Connolly
President and CEO