

June 1, 2020

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Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS–1744-IFC  
Mail Stop C4–26–05  
7500 Security Boulevard  
Baltimore, MD 21244–1850

**Re: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC)**

Dear Administrator Verma:

The American Geriatrics Society (“AGS”) greatly appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the interim final rule to respond to the COVID-19 public health emergency (PHE) (CMS–1744-IFC).<sup>1</sup>

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (“NPPs”) who are devoted to improving the health, independence and quality of life of all older adults. Our members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician assistants, pharmacists, and internists who are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. We provide leadership to healthcare professionals, policymakers, and the public by implementing and advocating for programs in [patient care](#), [research](#), [professional](#) and [public education](#), and [public policy](#).

All of our clinician members have been on the frontlines of the battle against COVID-19 with some of our most vulnerable older Americans. We applaud CMS’ efforts to revise Medicare payment rules and give physicians and health care providers enhanced flexibility to adapt care practices to reduce the risk of exposure for patients and healthcare practitioners and to better manage scarce healthcare resources. The agency’s rapid actions and ongoing efforts to respond to questions and address provider needs has helped AGS members be able to continue to provide high quality care to our patients in a highly uncertain environment.

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<sup>1</sup> CMS. Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. 85 Fed. Reg. 19230, April 6, 2020.

The changes adopted in this rule, a second IFC published in May<sup>2</sup>, and other CMS waivers and rulings are far-reaching and have dramatically changed key elements of the healthcare landscape. Our comments focus on changes that CMS has adopted during the PHE which we recommend be maintained after the PHE has expired. In particular, we recommend that CMS:

- Retain improvements to coverage and payment for telehealth services including keeping the newly added E/M services on the telehealth list, continuing to allow mobile computing devices to be considered interactive telecommunications system, and continuing to make payment at the non-facility rate when the physician submits a claim using place of service 11, and work with Congress to eliminate statutory barriers to allow broader access to telehealth services as well as lay the groundwork for the response to the next emergency;
- Maintain coverage and separate payment for audio-only telephone evaluation and management (E/M) services (99441, 99442, 99443);
- Continue other flexibilities related to provision of services through interactive telecommunications;
- Evaluate whether the findings that allow Medicare to pay for skilled nursing facility (SNF) services without a 3-day qualifying stay should be extended to apply after the expiration of the PHE.
- Consider changes to conditions of participation for SNFs to address workforce issues which have affected care provided during the PHE and will continue to be important after the PHE expires.

We describe these recommendations in greater detail.

#### **A. Retain Improvements to Telehealth Services**

The importance of telehealth during this pandemic cannot be understated. During the PHE, CMS allowed telehealth to be used in numerous instances when it would not otherwise have been available. We believe that telehealth services, when appropriate, will continue to play an important role in expanding access to health care services once the COVID-19 pandemic ends. In the near term, we expect telehealth will be essential to meeting patient care needs when the risk of infection remains high and distancing requirements will limit the number of people who can physically be in the office at any time. We urge CMS and Congress to work together to make the recent temporary telehealth expansions permanent. In particular, the AGS would like Congress to remove the geographic restrictions on telehealth services and allow telehealth services to be furnished to a beneficiary in their home.

From a regulatory perspective, we ask CMS to continue certain policies established during the PHE. We ask CMS to retain the E/M services added to the list of covered telehealth services during the PHE. Specifically, CMS should keep the following codes on the telehealth list:

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<sup>2</sup> CMS. Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program. 85 Fed. Reg. 27550, May 8, 2020.

- Emergency Department Visits - 99281 - 99285
- Initial and Subsequent Observation and Observation Discharge Day Management - 99217 - 99220, 99224 - 99226, 99234 - 99236
- Initial Hospital Care and Hospital Discharge Day Management - 99221 - 99223, 99238 - 99239
- Initial Nursing Facility Visits and Nursing Facility Discharge Day Management - 99304 - 99306, 99315 - 99316
- Domiciliary, Rest Home, or Custodial Care Services - 99327 - 99328, 99334 - 99337
- Home Visits - 99341 - 99345, 99347, 99349 - 99350
- Care Planning for Patients with Cognitive Impairment - 99483

We also urge CMS to extend the exception established for the PHE that clarifies that mobile computing devices can be considered interactive telecommunications system for purposes of telehealth. AGS members strive to appropriately protect patient privacy but our experience with the HIPAA compliant platforms that are currently available suggests that only allowing telehealth through use of such technology will severely impact patient's access to their health care providers on these platforms. We also recommend that CMS continue to make payment at the non-facility rate for the distance service when the physician submits a claim indicating the service was furnished in the physician's office (place of service 11).

While we believe these improvements provide important avenues for furnishing services in instances where the patient might not otherwise have access to care and particularly to the specialized care provided by our members, we do not think that telehealth services should completely replace face-to-face visits. It is important for physicians and other health care professionals to continue to see patients in person but the appropriate frequency of face-to-face interactions may vary by patient. We offer to work with CMS to develop guidance for appropriate utilization of telehealth services, including the appropriate frequency for services such as subsequent care provided to patients in inpatient settings such as hospitals and SNFs, to address these concerns.

We also recommend that CMS use the experience with the COVID-19 PHE to prepare for the next emergency. Many of the issues that CMS has addressed through waivers and enforcement discretion during this PHE, such as reducing billing restrictions on telehealth and telephone services, could be resolved by establishing capitated payments for primary care services and facilitating and supporting visits in the patient's home. CMS has been testing these type of care approaches through models such as the Comprehensive Primary Care Plus Model and the Independence at Home Demonstration. We urge CMS to consider policy changes that could better prepare the agency and the healthcare community to deal with emergencies 5 or 10 years in the future.

Finally, for many years, physicians and other non-physician practitioners have cared for patients when the practitioner or patient traveled, and electronic health records have increased the ability for a practitioner to promptly address patient needs when out of the office. A patchwork of inconsistent state law and regulation creates an impediment to continuity of care when the practitioner and patient are not in the same state and those challenges have become more apparent and of greater concern with more widespread and emergent use of telehealth and audio-only services. We appreciate CMS' efforts to address these issues during the PHE. While we do not advocate for a federal medical licensure medical, going forward we do believe some regulation of interstate practice could facilitate better care by allowing for continuity of care for established patients who are out of state via telehealth services.

## **B. Maintain Coverage and Payment for Audio-Only Telephone E/M Services**

In this IFC, CMS provided coverage and making separate payment for telephone E/M service codes (99441 - 99443) that describe audio only services and which had previously been non-covered by Medicare. In the May IFC, CMS improved access to these services by cross walking the payment for the telephone service codes to the RVUs for the analogous outpatient E/M visit codes. We strongly urge CMS to maintain both the coverage and separate payment for telephone services after the expiration of the PHE.

As described above, AGS greatly values the expanded access to telehealth services. However, we note that even with those improvements, there are many instances where telehealth cannot meet patient needs. Among our patient population of older adults, many are not comfortable with or do not have the resources (e.g. do not own a smart phone) or know-how to operate various audio and video capable software and mobile applications and restrictions on interactions mean these patients cannot have other individuals provide assistance with technology. Patients with cognitive impairment, low vision, and/or hearing loss face additional barriers that can prevent use of more advanced technology for telehealth services. A pre-COVID survey by the University of Michigan found that 47 percent of adults between 50-80 had difficulty using technology and 39 percent had difficulty seeing or hearing the health care professional.<sup>3</sup> In addition, regardless of their technological capabilities, patients who live in parts of the country without reliable access to broadband internet cannot receive services by telehealth. A 2019 survey by Harvard found that roughly a quarter of adults in rural America could not access needed health care and that the distance and difficulty in getting to the health care location was a factor for 23 percent of those individuals. The study also found high satisfaction among those patients who were able to use telehealth services. However, 21 percent of rural adults said access to high-speed internet is a problem.<sup>4</sup> So while the steps CMS has taken to reduce the location and technology restrictions on telehealth will help improve access to care overall, there are still individuals who need care and are unable to access it in person or through telehealth.

Audio-only telephone services have been an essential tool during the COVID-19 PHE and we believe that these services will continue to be valuable. In addition to the technical challenges of using telehealth with some patients, there are statutory limitations that will apply to telehealth after the PHE. Maintaining coverage for the audio only E/M codes will enable physicians to evaluate patients who they believe are at high risk for getting COVID if they go to the physician's office and/or who may be reluctant to visit a healthcare facility even after the immediate COVID crisis has past. It will also allow physicians to maintain continuity of care with patients on travel or who live in another location part of the year.

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<sup>3</sup> University of Michigan National Poll on Healthy Aging. "Virtual Visits: Telehealth and Older Adults." October 2019. [https://deepblue.lib.umich.edu/bitstream/handle/2027.42/151376/NPHA\\_Telehealth-Report-FINAL-093019.pdf?sequence=4&isAllowed=y](https://deepblue.lib.umich.edu/bitstream/handle/2027.42/151376/NPHA_Telehealth-Report-FINAL-093019.pdf?sequence=4&isAllowed=y)

<sup>4</sup> NPR, Robert Wood Johnson, Harvard T.H. Chan School of Public Health. Life in Rural America: Part II. May 2019, [https://media.npr.org/documents/2019/may/NPR-RWJF-HARVARD\\_Rural\\_Poll\\_Part\\_2.pdf](https://media.npr.org/documents/2019/may/NPR-RWJF-HARVARD_Rural_Poll_Part_2.pdf).

Maintaining care relationships can be especially important for beneficiaries who spend time in areas without adequate access to a geriatrician.<sup>5</sup>

As CMS notes in the IFC, coverage of audio-only telephone services is consistent with recent decisions to cover other non-face-to-face services, such as virtual check-in services and remote patient monitoring. Maintaining coverage of these services after the PHE will allow physicians to bill for the full spectrum of care that needs to be provided. We note that CPT guidance limits use of the telephone E/M codes to established patients and indicates that they are to be used for care initiated by the patient. We do not believe the RVUs CMS set for the telephone E/M codes prior to the PHE appropriately recognize the cognitive work required nor do they reflect the practice expense cost for these services in an environment where they are likely to represent a greater share of services than were previously expected. Therefore, we urge CMS to maintain the payment rules established during the PHE for 99441 - 99443, until the AMA CPT Editorial Panel and Relative Value Scale Update Committee (RUC) have the opportunity to make updated recommendations for appropriate language and RVUs for those codes.

In addition, to avoid confusion about appropriate licensure following the PHE, we ask that CMS clarify that the physician is furnishing the telephone service at their location (e.g., the physician office) and that is the site of service that should be included on the claim. We also ask that CMS allow diagnoses made during appropriately provided telephone services to be included in the risk adjustment methodology for Medicare Part C plans.

### **C. Continue Other Flexibilities Using Interactive Telecommunication Technology**

We also urge CMS to continue to allow other flexibilities established under the PHE, including those related to provision of direct supervision and prescribing controlled substances. CMS is allowing the provision of direct supervision to be furnished through interactive telecommunication technology and specifically applied this flexibility to primary care services provided in a teaching setting. During the PHE, CMS allowed all levels of office/outpatient E/M services in primary care centers to be furnished under the direct supervision of a teaching physician and does not require the physician to be physically present during the key portion of the service. We recommend that CMS maintain this flexibility for direct supervision, including for primary care services in a teaching setting, after the PHE to allow practices to best adapt to meeting patient care needs in the post-Covid environment and to better facilitate the development and training of primary care practitioners. We also ask that CMS clarify that the supervising physician does not have to participate through interactive telecommunication during each service but must be available through interactive telecommunication in the same manner as would apply if the physician was physically present in the facility and providing direct supervision.

We also ask that CMS work with other agency partners such as the Substance Abuse and Mental Health Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to maintain flexibilities for patients to receive certain prescriptions for controlled substance following evaluation via telehealth.

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<sup>5</sup> Health Resources & Services Administration. (2017). National and Regional Projections of Supply and Demand for Geriatricians: 2013-2015. Available at <https://bhwh.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/GeriatricsReport51817.pdf>

#### **D. Evaluate Whether Findings Support Continued Access to SNF Services without a 3-Day Qualifying Stay**

The Medicare statute currently requires that a beneficiary have a 3-day hospital stay before being eligible for covered SNF services. The statute also allows the Secretary of Health and Human Services (HHS) to provide for additional coverage of SNF services if coverage of such services will not increase total Medicare payments:

The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit ...<sup>6</sup>

CMS exercised this authority during the PHE to provide coverage for SNF services to beneficiaries without a 3-day hospital stay.

The AGS strongly urges CMS to evaluate whether this finding should also apply after expiration of the PHE. The 3-day qualifying stay is an antiquated requirement that restricts beneficiary access to care in the most appropriate setting and may lead to increased Medicare costs as a result. A recent JAMA article notes that both experience with FFS Medicare claims and Medicare Advantage patients suggests that eliminating the 3-day requirement will not increase Medicare spending.<sup>7</sup> Moreover, COVID is not going to disappear. It will likely become endemic and/or cause periodic epidemics; hospitals and patients need the flexibility to determine the best site of care for older vulnerable patients which in many cases will not be a hospital. The statutory language provides broad authority to the Secretary to determine when and for how long the services that are not post-hospital can be covered. We urge CMS to use that authority to continue access to SNF services without the qualifying hospital stay. If CMS is reluctant to make this extension permanent, we recommend that CMS extend this policy for three years and then evaluate the clinical benefits and the monetary cost of the extension to make a determination as to whether to continue the extension beyond three years.

#### **E. Consider Changes to Conditions of Participation for SNFs to Address Workforce Issues**

SNFs and nursing homes care for the oldest and most chronically ill patients. That population has been particularly vulnerable to COVID-19 and experienced a high fatality rate. To provide better support for the practitioners and staff caring for patients in those settings, we urge CMS and Congress take the following steps to strengthen the SNF and nursing home workforce by requiring the following:

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<sup>6</sup> Social Security Act (SSA) 1812(f).

<sup>7</sup> Patel, N., JM Slota, BJ Miller. "The Continued Conundrum of Discharge to a Skilled Nursing Facility After a Medicare Observation Stay." JAMA Health Forum, May 26, 2020, <https://jamanetwork.com/channels/health-forum/fullarticle/2766649>.

- Adequate pay such that staff do not need to work in multiple facilities which increases the potential for cross-infecting patient populations;
- Paid family and medical leave for staff, including certified nursing assistants, dietary staff and environmental support staff;
- Development of policies and procedures for screening staff for infection and establishing appropriately balanced requirements for quarantine;
- Training on infection control and the use of personal protective equipment (PPE);

We encourage CMS to also consider changes that are needed to support the workforce that is providing home and community-based services to ensure the health and safety of both the workforce and the older persons that they care for.

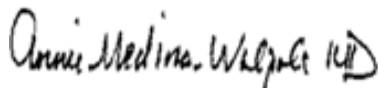
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In summary, AGS recommends that, after the expiration of the PHE, CMS continue to provide access to needed services established during the emergency. Specifically, we ask that CMS:

- Retain additional E/M services on the list of covered telehealth services, work with Congress to remove statutory barriers limiting access to telehealth services, and prepare for the next emergency;
- Maintain coverage and separate payment for audio-only telephone services (99441-99443);
- Continue other flexibilities related to provision of services through interactive telecommunications;
- Consider whether the finding that allowing coverage of SNF services without a qualifying 3-day hospital stay will not increase total Medicare spending is still in effect and therefore those services should continue to be covered;
- Take steps to support the SNF, nursing home, and home-care workforce.

Thank you for the opportunity to submit these comments and for your attention to these concerns. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, [agoldstein@americangeriatrics.org](mailto:agoldstein@americangeriatrics.org) or Anna Kim, [akim@americangeriatrics.org](mailto:akim@americangeriatrics.org).

Sincerely,



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