AdvocateAuroraHealth

March 1, 2021

Chairwoman Anna Eshoo House Energy & Commerce Subcommittee on Health 2125 Rayburn House Office Building Washington, DC 20515	Ranking Member Brett Guthrie House Energy & Commerce Subcommittee on Health 2125 Rayburn House Office Building Washington, DC 20515

Re: Written Testimony Submitted to the House Energy & Commerce Health Subcommittee for the March 2, 2021 Hearing Record, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care"

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of Advocate Aurora Health (Advocate Aurora), we thank you for holding a hearing on March 2, 2021 titled, "The Future of Telehealth: How COVID-19 is Changing the Delivery of Virtual Care." We very much appreciate your leadership on this important topic and thank you for the opportunity to submit this statement for the hearing record. We thank you in advance for your consideration of our recommendations for how to fully harness the potential telehealth holds for overcoming some of the most challenging health care issues facing our nation, including increasing access to quality care, lowering costs, and eliminating health care disparities by addressing the socioeconomic determinants of health (SDOH).

Overview of Advocate Aurora

Advocate Aurora is a leading employer in the Midwest with more than 75,000 team members, including more than 22,000 nurses and the region's largest employed medical staff and home health organization. The system serves nearly 3 million patients annually; across both Illinois and Wisconsin, in particular, we serve an estimated 695,000 Medicare beneficiaries and more than 485,000 individuals with Medicaid coverage.

With more than 500 sites of care, Advocate Aurora is engaged in hundreds of clinical trials and research studies, and is nationally recognized for its expertise in cardiology, neurosciences, oncology, and pediatrics. The organization contributed $2.2 billion in charitable care and services to its communities in 2019. Advocate Aurora brings its strengths, assets, and commitment to delivering value and outcomes to individuals, families, and communities throughout Illinois and Wisconsin.

Advocate Aurora & Telehealth

Advocate Aurora has long been engaged in the provision of care through telehealth, as it is an important tool in reaching rural and underserved communities, including individuals with special needs, such as people who are deaf and hard-of-hearing. For example, we are proud that more than 15 years ago we were the only Chicago area provider to offer tele-psychiatry visits using videoconferencing and providers who speak American Sign Language (ASL) to deaf and hard-of-hearing patients who were living in southern Illinois. These patients had unmet mental health needs but there were no providers in the community who spoke ASL and an audio-only visit is ineffective and inappropriate. By offering video-

tele-psychiatry with ASL speakers, patients could access the specialty care they needed without the burden of having to travel. Since that time, we have significantly expanded our telehealth and digital medicine offerings in Illinois and Wisconsin.

We connect to our patients through videoconferencing, remote monitoring, electronic consults, and wireless communications and we deploy these technologies to provide primary, urgent care, and specialty services. The strategic utilization of telehealth – both prior to and during the public health emergency (PHE) – allows us to offer patients an important, safe, and convenient care option.

Advocate Aurora Telemedicine ED Triage

For example, prior to the PHE, we successfully implemented remote video monitoring technology to help reduce overcrowding at Aurora Sinai Medical Center's Emergency Department (ED) in Milwaukee, Wisconsin, one of our busiest EDs. This telemedicine program allows patients to be seen initially by an Advocate Aurora provider via video when they arrive, with a nurse at the patient's side. By having additional providers available via telemedicine – with triage assistance and on-site provider support – patients are seen by a clinician faster and, in turn, they experience a reduced time to diagnoses and quicker initiation of treatment.

- The program has helped to reduce door-to-provider times from 60 minutes to about 10 minutes, on average.
- The average length of stay has declined by 40 minutes.
- The leave-without-being-seen rate has plummeted from 8% to 2%.
- Overcrowding in the ED has decreased significantly.

Advocate Aurora and Telehealth During the PHE

We are eager to sustain the recent advances made in the utilization and adoption of telehealth; while the advantages and power of telehealth have been known for decades, the importance of virtual care has become profoundly clear in the past year during the PHE. Starting in March 2020, providers and patients alike sought ways to interact that reduced their risk of exposure to COVID-19. Many providers could not be in the office or at the hospital due to COVID-19 restrictions but could still see patients through virtual care. Telehealth helped reduce unnecessary patient and provider exposure to COVID-19 and allowed us to preserve scarce PPE during shortages.

Many patients, including home care patients, were fearful of seeing providers in person but were eager to engage in a visit through audio or video means. Further, many patients have mobility issues, disabilities, or transportation challenges that make traveling to an office, clinic, or hospital campus extremely burdensome even in non-pandemic times. With vast disruption of public transportation systems and patients experiencing greater stress overall, telehealth allowed us to provide convenient, continuity of care for our patients across the care spectrum – primary, specialty, post-acute, chronic disease management, etc.

Before the pandemic in January 2020, about 300 Advocate Aurora providers were performing virtual

health visits and at the end of the year, 4,663 providers were conducting appointments via telehealth. During this time, we provided a total of 876,000 virtual visits, up significantly since before the pandemic. Our Family Practice providers accounted for 27% of these visits while our Internal Medicine providers accounted for 18% followed by Behavioral Health 14% and Cardiology 6% while other specialties accounted for the other telehealth visits.

Advocate Aurora Supports Making Permanent the PHE-Related Telehealth Policy Changes

Advocate Aurora very much appreciates the changes that both the Centers for Medicare and Medicaid Services (CMS) and Congress have made since the start of the PHE to ensure that patients can receive care via telehealth, should they so choose. Appended to this testimony please find comments that Advocate Aurora's Health at Home submitted in December 2020 to CMS in response to the agency's Request for Information on Regulatory Relief to Support Economic Recovery. Specifically, the comments submitted detail which regulatory changes have been beneficial to the provision of care and which changes should be extended or made permanent. We thank you for your attention to that correspondence from our colleagues and enumerate below a number of the flexibilities and waivers currently available that we respectfully request be made permanent. We understand that some of the waivers and flexibilities can be made permanent under existing CMS authority, while others require Congressional action. We urge you and your colleagues to work with CMS to ensure all of these policies are made permanent so patients can continue to benefit from that telehealth delivered care offers them. Specifically, we ask that you continue to allow:

- All patients, irrespective of their geography (e.g., rural) and physical location (e.g., home), to receive telehealth services in the location of their choosing.
- Medicare to pay for telehealth services at the same rate as in-office visits for all diagnoses.
- Practitioners to provide telehealth services to both new and established Medicare patients.
- Practitioners to provide audio-only telephone evaluation and management visits for new and established patients; this is especially important for patients who may not have internet access or a smart phone.
- Practitioners licensed in one state to be reimbursed for services provided to Medicare beneficiaries in another state and reduction of burdens preventing reciprocity in state licensures.
- Practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists to provide – and be reimbursed for – telehealth, virtual check-ins, e-visits, and telephone calls to patients.
- Practitioners to provide a greater range of services to beneficiaries via telehealth, including ED visits.
- Medical screening exams (MSEs), a requirement under Emergency Medical Treatment and Labor Act (EMTALA), to be performed via telehealth.

Further, we very much appreciate that CMS and the Office of Inspector General at the Department of Health and Human Services (HHS) have offered relief from enforcement of Stark Self-Referral and Anti-Kickback laws during the PHE. As you know, while well intended when they were designed, the nature of health care delivery has changed significantly in the decades since these laws were passed and their implementing regulations promulgated. We urge that many of these flexibilities be made permanent so

that patients can have access to the technologies they need to benefit from advances in virtual care. We are concerned that underserved and vulnerable patient populations may not have access to the needed technologies primarily used for telemedicine, including broadband internet access and smartphones, yet providers cannot provide financial help so patients can secure these needed tools.

Without a permanent change, hospitals face significant legal risk if they want to provide a subsidy to their physicians to purchase telehealth technologies, like specialized tablets to perform remote patient monitoring, or if they want to give patients, free of cost or at reduced prices, devices such as wearable "stethoscopes", blue-tooth enabled-digital blood pressure cuffs, or a virtual care kit for a home examination. Patients who cannot afford the out-of-pocket costs for these devices, apps, etc. will be unable to benefit from innovative, patient-centered virtual care. This further exacerbates inequities and health disparities and prevents providers from being able to address many SDOH.

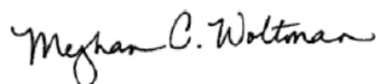
We appreciate the recent changes CMS and HHS have made to the Stark and Anti-Kickback regulations but we urge federal policymakers to further modernize these outdated laws and regulations so that underserved and vulnerable patients can have access to the care and tools they need and deserve.

Summary

Again, we thank you for the opportunity to submit this statement for the hearing record and we stand ready to work with you to ensure that the advances made in leveraging telehealth innovations are sustained so we can continue to improve and transform health care in America, particularly for our most vulnerable patient populations. We urge you and your colleagues to make permanent the PHE-related telehealth waivers and flexibilities.

On behalf of Advocate Aurora's physicians, nurses, other health professionals and associates, and the patients and families we serve, we thank you for your leadership and commitment to ensuring that we as a nation sustain the gains made in expanding access to care via telehealth and digital medicine offerings. Should you or your staff have any questions or if we can be of any assistance on this or other matters, please do not hesitate to contact me (meghan.woltman@advocatehealth.com or 312-933-0455) or Tony Curry (703-786-2571, anthony.curry@aah.org). We look forward to working with you throughout the 117th Congress to improve the health and well-being of the communities we serve.

Sincerely,



Meghan Woltman
Interim Chief Government Affairs Officer
Advocate Aurora Health

December 28, 2020

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

RE: Regulatory Relief to Support Economic Recovery: Request for Information

Submitted electronically via www.regulations.gov

Dear Administrator Verma:

On behalf of Advocate Aurora Health (Advocate Aurora), the 10th-largest not-for-profit integrated health care system in the country, and Advocate Aurora Health at Home, I am writing to express our appreciation for the opportunity to respond to your request for information (RFI) on regulatory relief to support economic recovery. We are grateful that Executive Order 13924 directed federal agencies to address the "economic emergency created by the COVID-19 pandemic by rescinding, modifying, waiving, or providing exemptions from regulations and other requirements that may inhibit economic recovering, consistent with application law and with protection of the public health and safety" and that you and the Centers for Medicare & Medicaid Services (CMS) for providing numerous flexibilities and waivers throughout this year to facilitate access to care and reduce burdens on patients and providers.

We thank you in advance for your attention to our feedback regarding which regulatory changes have been beneficial to the provision of health care, patients, and providers and which changes should be extended or made permanent. Further, for your reference below, we have included several additional changes that we urge CMS make to remove regulatory barriers that impede efficiency and innovation in the provision of home health care to Medicare beneficiaries. Extending or making permanent a number of changes combined with promulgating additional modifications would allow our home health and hospice providers deliver improved and more cost-effective care to the patients we are so privileged to serve.

Experience with COVID-19

Since the declaration of the National Emergency by President Trump and the Public Health Emergency (PHE) declared by U.S. Department of Health and Human Services (HHS) Secretary Alex Azar earlier this year, your office responded quickly with immediate action to issue waivers and flexibilities to assist both providers and frontline health care workers to expeditiously care for patients while adapting to the ever-changing COVID-19 care environment.

As a post-acute provider in a large health system, we worked with our system hospitals and community based skilled nursing facilities to ensure access for patients infected with COVID-19, offering home hospital programs and expanding capacity for virtual health. As we continue to navigate providing care

in a pandemic, we have found that some of the new flexibilities and innovations provided a better patient experience with the same high-quality outcomes, and that these efficiencies and changes would be beneficial for patients, regardless of whether we were providing care during a PHE. To that end, we ask that you consider making permanent the following waivers and regulatory flexibilities so these changes can benefit patients and providers beyond expiration of the PHE.

Communication Technology-Based Services (CTBS). [Page 75732]

Advocate Aurora has had a robust virtual health program for several years providing tiers of patient support using biometric monitoring, video visits, and telephonic support. As such, we very much appreciate that CMS provided flexibility regarding services provided via telecommunications technology that are not considered Medicare telehealth services. Specifically, we thank CMS for recognizing that these services could reduce or eliminate the need for a patient to have an in-person and that these services not be limited to "established patients." Further, we appreciate that the agency recognized that physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) "might also utilize virtual check-ins and remote evaluations" and provided designated HCPCS codes for billing of these important services. The provision of these services advances patient-centered care and helps reduce patient burden with respect to traveling to see a provider in-person, which for elderly, ill, and/or disabled patients can be particularly challenging. As such, we strongly urge CMS to consider making these changes permanent.

Telephone Evaluation and Management (E/M) Services Codes. [Page 75733]

We thank the agency for also providing – during the PHE – payment for certain CPT codes (98966-98968, 99441-99443) and that these services are extended to both established and new patients. Further, we appreciate that during the PHE, practitioners who cannot separately bill for E/M codes, such as PTs, OTs, and SLPs, are permitted to bill CPT codes 98966-98968. We strongly urge the agency to maintain this flexibility for at least six months following the end of the PHE to allow for patients and providers to transition back to the manner in which telephone E/M services are normally permitted and provided.

Clarification of Homebound Status under the Medicare Home Health Benefit. [Page 75733]

Given the significant threat that COVID-19 poses to individuals, families, and communities and the elevated risk faced by older individuals and individuals with chronic, serious, life-threatening, and/or disabling conditions, it was essential that the agency broaden the definition of homebound to "include beneficiaries whose physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if a patient has a condition that makes them more susceptible to contract COVID-19." We very much appreciate this important recognition to consider this broader group of individuals as eligible for home care and urge the agency to maintain this definition for six months following the end of the PHE because many of these individuals likely will face additional challenges in accessing the health care system and having care provided to them at home, should they choose and their provider deem appropriate, should be available to them.

Use of Telecommunications Technology Under the Medicare Home Care Benefit, [Page 75733] and Use of Telecommunications Technology Under the Medicare Hospice Benefit, [Page 75734]

When home care patients also are receiving hospice, it is essential that care and services are coordinated and continuity of care maintained. We appreciate that during the PHE, CMS has amended regulations on an interim basis "to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' [sic] terminal illness and related conditions without jeopardizing the patients' [sic] health or the health of those who are providing such services during the PHE." This flexibility has played an integral role in ensuring that Medicare home care patients who need hospice care continue to receive both types of services and it has been useful for reporting and cost capture purposes that costs associated with the use of telecommunications technology can be included under "other patient care services" on Worksheet A. We thank the agency for this flexibility and urge the agency to allow this change to be made permanent as it allows for greater flexibility in hospice staffing and facilitates the timely provision of hospice care to patients in need.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act. [Page 75736] and Eligibility for Telehealth. [Page 75749]

We commend CMS for significantly expanding the list of codes for which reimbursement is available for Medicare telehealth services during the PHE. The addition of these services has facilitated the use of telecommunications technology as a safe substitute for in-person services. Further, the elimination of the frequency limitations and other requirements associated with services furnished via telehealth has had a significant, positive impact on our ability to provide and maintain care, while keeping patients and health professionals safe. Moreover, we very much appreciate that CMS has waived the requirements that that specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. These changes have helped ensure that we can reduce COVID-19 exposure for patients and our health professionals, which in turn, has assisted in reducing COVID-19 transmissions and sustained availability of care. In particular, we have appreciated that a number of the additional services/codes pertain to outpatient physical therapy and that health care professionals, including PTs, OTs, SLPs, and others to receive payment for Medicare telehealth services. We realize that many of these changes require Congress to change underlying Medicare statute; however, we also know that some modifications can be undertaken by CMS and that the agency can extend these waivers beyond the PHE. As such, we strongly urge the agency to extend these waivers and flexibilities for another 18 months past the year in which the PHE ends to allow patients to continue to benefit from this expansion of services and for the agency to collect and analyze data to assess the impact of these changes on patients, providers, and the government, as a payor.

Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement. [Page 75736]

The use of telecommunications technology by the hospice physician or nurse practitioner (NP) for the face-to-face visit when a visit is for recertification has increased efficiency for providers and improved access to care for patients. Providers, patients, and family members all have embraced this efficient and patient-centered approach as this allows for prompt recertification, maintaining continuity of care and eliminating barriers. We urge that you make this change permanent, so it is available as an option for patients and providers, even after the PHE ends.

Home Health Orders from APPs. [Page 75736] and Care Planning for Medicare Home Health Services. [75737]

We appreciate that CMS has recognized the important role that NPs, clinical nurse specialists (CNSs), and PAs play in the provision of care to Medicare beneficiaries in home health. Specifically, we thank the agency for making changes to allow advanced practice providers (APPs) to order home health services, establish and periodically review a plan of care, certify and recertify the plan of care for home health patients. NPs, CNSs, and PAs have firsthand knowledge of the patient's current course of care before transitioning them to the home health setting; as such, allowing these professionals to order home health facilitates improved care coordination among providers and reduces delays and barriers to access to care. We thank CMS for amending regulations to define NPs, CNSs, and PAs as allowed practitioners for certifying, establishing, and periodically reviewing the plan of care, as well as supervising the provision of home health items and services. Further, we note that the regulations have been changed also to allow these practitioners to conduct the face-to-face encounter for certifying eligibility but acknowledge that the certifying practitioner may be different from the provider performing the face-to-face encounter. As noted in the RFI, these regulation changes are permanent and are not time limited to the PHE and as such, we believe they will have a profound and lasting positive impact on increasing access to home health, as many beneficiaries are medically managed by advanced practice nurses (APNs) and PAs in many other areas of the health care continuum, such as skilled nursing facilities and office-based settings.

Allow Occupational Therapists (OTs), Physical Therapists (PTs), and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients. [Page 75747]

This blanket modification importantly allows any rehabilitation professional, acting within their state scope of practice law, to perform the initial and comprehensive assessment. Home health professionals work as a team to provide a comprehensive care plan to patients and allowing any discipline to conduct the initial home visit and comprehensive assessment supports this team-based approach. We have had success, for example in cross-training OTs to conduct the OASIS assessments. We found that this improves access to care for patients, as well in situations where staffing is affected offers patients timely access to an initial assessment, decreasing wait times for the initiation of home health services. Having this flexibility is critical and making this waiver permanent would be incredibly helpful to maintain this improved efficiency in the initiation of home care for Medicare beneficiaries.

Waive Onsite Visits for Home Health and Hospice Aide Supervision. [Page 75744]

We recognize the importance of assuring personal care is provided safely and effectively – and consistent with the care plan – to vulnerable patients. However, we believe this does not always need to be done onsite. We have found supervision can be done in an effective and efficient manner by talking via phone to the patient and nursing aide. These team members also participate in team conferences, which allow for the adequate exchange of information to assure the care plan is reviewed and revised as necessary. We ask that for the future, CMS provide agencies the flexibility of performing onsite or virtual supervisory visits for patients every 14 days.

Clinical Records for Home Health Agencies [Page 75758]

We thank CMS for extending the deadline for completion of the requirement that HHAs need to meet to provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient). Specifically, we appreciate that CMS will allow HHAs ten business days to provide a patient's clinical record, instead of four. We respectfully request that CMS extend this waiver for six months following the end of the PHE; additional time will allow HHAs to adjust to the provision of care and services following the PHE and otherwise support compliance with this requirement.

Review Choice Demonstration for Home Health Services Claims Processing Requirements [Page 75760]

We very much appreciate that effective March 29, 2020, CMS paused the claims processing for the Review Choice Demonstration (RCD) until the PHE has ended. We understand that as of now, "following the end of the PHE for the COVID-19 pandemic, the MAC [Medicare Administrative Contractor] will conduct post payment review on claims subject to the demonstration that were submitted and paid during the pause.

Additional Recommended Changes

Over the April through June 2020 period – at the height of the PHE – our home health team made more than 51,000 telephonic and 300 video visits to patients in order to sustain continuity of care and reduce concerns of possible COVID-19 transmission. These calls were instrumental in keeping patients safe in their home while executing a home care plan necessary to avoid preventable emergency room visits or hospital admissions. In fact, our team created a Home Hospital program, which allowed patients with COVID-19 who would have been admitted to the hospital to return home from the emergency room and receive provider visits, biometric monitoring, oxygen, and nursing support. This program was successful in creating our "hospital without walls" approach and expanding capacity in our brick and mortar institutions. This patient-centered approach helped ensure that there were inpatient beds available to those patients who needed them while patients who did need a higher level of care, but not at the hospital, were able to receive care and services in the safety and comfort of their own homes.

Advocate Aurora participates in three Accountable Care Organizations in two states and manages more than 322,000 covered lives in the MSSP where risk is shared and managed. Our goal is to have every patient at the right level of care utilizing services that are appropriate to meet their health care needs at any given time. Virtual health is cost effective and should be used with every level of provider to assure continuity of care and patient access, and to avoid the seeking of higher levels of care when they are unnecessary. Therefore, we are disappointed that CMS does not recognize virtual home health visits as bona fide encounters. Leaders in the home health industry are interested in partnering with CMS to develop a reimbursement methodology that supports the delivery of telehealth to home health patients by home health agencies.

We recognize that current statute prohibits "payment for services furnished via telecommunications systems if such services substitute for in-person home health services ordered as part of a plan of care." However, we believe it is time for CMS to work with home health providers to explore innovative ways

to design and implement a reimbursement structure for virtual encounters in the home health setting that supports the deployment of technology to the benefit of Medicare beneficiaries, the Medicare Trust Fund, and providers.

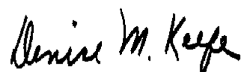
For example, *using its existing waiver authority*, CMS could allow participants in the MSSP to provide telehealth and other virtual visits in lieu of in-person visits and have such visits substitute for in-person home health. MSSP participants have built-in incentives to provide patient-centered care that keeps Medicare beneficiaries healthy and out of the hospital, because they are held accountable for both costs and outcomes. There is no incentive for MSSP participants to "skimp" or provide virtual care that should be provided in-person. Working together, we could enumerate an agreed upon list of the types of care, services, and encounters that all parties agree could safely and effectively be provided virtually and have those be on the "approved" list for permitted to be substituted for in-person visits. Further, we could identify the types of patients and circumstances under which virtual care can be provided in lieu of face-to-face. We welcome the opportunity to discuss this idea and explore others with you and your staff.

While it does not go as far we would like, we wish to thank the agency for making permanent under the 2021 Home Health final rule the change to "allow the use of telecommunications technology included as part of the home health plan of care as long as the use of such technology does not substitute for ordered in-person visits." In addition, we appreciate that the agency will soon allow "HHAs to continue to report the costs of telehealth/telemedicine as allowable administrative costs on line 5 of the home health agency cost report." Furthermore, we recommend that for purposes of data collection, virtual encounters be listed on future home health claims to better understand how these tools are used to benefit patients.

Conclusion

On behalf of the tens of thousands of individuals and families we serve across communities throughout Illinois and Wisconsin, we thank you for soliciting feedback from the public regarding which regulatory changes that have been made in response to the COVID-19 PHE have been beneficial, which should be maintained either through longer extension or permanence. As always, we stand ready to be a resource to the agency on these and other issues regarding the provision of quality care to Medicare beneficiaries who are homebound and/or in need of hospice care. Please do not hesitate to contact me, or Tony Curry, Advocate Aurora Director, Federal Government Affairs (Anthony.Curry@aah.org, 703/786-2571).

Sincerely,



Denise Keefe
President
Post-Acute Division
Advocate Aurora Health