September 24, 2020

Seema Verma
Administrator, Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Attention: CMS–1734–P

Dear Administrator Verma,

On behalf of URAC, I respectfully offer our comments in response to the CMS's proposed Medicare Physician Fee Schedule (MPFS) for calendar year 2021.

URAC is a nationally recognized accrediting entity with thirty years of experience accrediting managed car, pharmacy benefit managers, pharmacies, and provider organizations. Given the public trust placed in us via our multiple CMS deemed programs, we believe it vital that we remain an independent source of quality and as such we do not sell consulting services of any type. URAC is the nation's leading accreditor of digital health technologies offering accreditation for telehealth and remote patient monitoring. We also offer a certification program for those technology companies that enable providers to deliver care remotely.

We are generally supportive of many of the proposed provisions for the MPFS for calendar year 2021 particularly those policies recognizing the important role that technology, namely telehealth, will play through the duration of the public health emergency and its growing role in the future of care delivery. We are also supportive of CMS's recognition of pharmacists for billing purposes particularly given their role as a vital component of our nation's fight against COVID-19.

During the pandemic, we have seen a surge of interest from organizations and stakeholders seeking insight on how to ensure quality care is delivered via remote technology. We've often heard telehealth described as the "wild west" which is why nearly 50 organizations over the last several months have chosen to pursue or have achieved one of URAC's digital health accreditations or certifications.

Enclosed with this letter please find our detailed comments related to specific elements of the MPFS where URAC's accreditation programs give us unique insight that may benefit your efforts.

We stand ready to share our expertise and the unique insight we have garnered during the public health emergency (PHE) as you seek to ensure access to high-quality care. Should you wish to discuss any of our comments in more detail please contact Aaron Turner-Phifer directly at aturner-phifer@urac.org.

Best,

Shawn Griffin, M.D.

Shawn Griffin, M.D.
President and CEO

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Academy of Managed Care Pharmacy

American Association of Preferred Provider Organizations

American Health Quality Association

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National Alliance of Healthcare Purchaser Coalitions

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Telehealth Services During and After the Public Health Emergency

Due to regulatory and statutory changes rightly made in the immediate response to COVID-19, patients utilized digital health platforms, tools, and services to ensure they received the care they required. As a result, telehealth usage increased dramatically both for Medicare beneficiaries and privately insured patients. We support CMS's proposal to continue to support live voice/video telehealth services for the duration of the public health emergency (PHE) and believe the continued employment of a sub-regulatory process to add additional services during the PHE is appropriate. Recognizing the statutory restrictions CMS faces in extending this support past the expiration of the PHE, we generally support CMS's proposed policy changes to expand Part B support for Medicare telehealth services, including the creation of a new Category 3 for services enabled during the PHE.

Clarification in § 410.78(a)(3)

URAC also supports CMS's proposal to permanently remove the second sentence of § 410.78(a)(3) which states that "[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system." URAC supports this proposal and the elimination of outdated discriminatory policies against modalities that have no legitimate basis. The elimination of this text will, as CMS notes, reduce confusion in instances where eligible devices, such as smartphones, are also used as a telephone for Medicare telehealth services.

Enable Rural Health Clinics and Federally Qualified Health Centers to Furnish Remote Physiologic Monitoring

We encourage CMS to ensure that Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are able to furnish remote physiologic monitoring (RPM) services during the PHE. FQHCs and RHCs are on the front lines of caring for America's most underserved populations and they are often the primary source of care for those patients at the greatest risk of COVID-19 infection and death. As such, these organizations need the ability and financial support to monitor key patient-generated health data (PGHD) metrics – especially for those receiving treatment for COVID-19. We encourage CMS to explore the potential range of solutions available to continue to support FQHCs and RHCs as they respond to COVID-19.

Virtual Direct Supervision

We believe services delivered virtually should meet or exceed the quality threshold of in-person care. We do not believe that new regulations or policies are required to allow for the deployment of technology but instead believe CMS should rely on the provider to determine how and when virtual care is appropriate.

During the PHE CMS took important steps to utilize technology for the purposes of medical supervision by revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. We believe that CMS is taking the proper approach to evaluate the value and impact on patient safety of such a permanent change. We believe it is likely that in certain scenarios virtual supervision can be done safely but in other scenarios it is not warranted. Should CMS move to make virtual direct supervision permanent, we recommend CMS simply allow for virtual direct supervision at the the discretion of the provider when judged to be clinically appropriate.

We also believe CMS is correctly concerned about the broader impact on program integrity regarding certain permanent expansion of telehealth and digital health services such as the change to direct supervision.

Given the overnight explosion of telehealth adoption, the deployment of many programs can be considered immature. While the vast majority of providers are certainly doing their best to adopt telehealth in appropriate ways, the present environment could allow for bad actors to take advantage of the reduced oversight from federal officials. If history is any guide, we believe that the current approach to program integrity need simply be expanded to accommodate increased telehealth adoption. We believe best practices that providers must adhere to is the appropriate oversight function similar to the standards that providers and facilities are expected to adhere to for access to Medicare, Medicaid, and commercial insurance reimbursement. We further believe that this can be accommodated through provider enrollment and deemed programs to ensure no burdensome additional administrative barriers are created in a manner similar to the requirements of hospitals, surgical centers, providers, home health agencies, and suppliers.

We believe that providers should be required to adhere to best practices in the following areas:

vii. Patient Consent & Disclosure
viii. Data Privacy & Security
ix. Credentialing
x. Clinical Guidelines & Oversight
xi. E-Prescribing
xii. Hardware/Software Functionality

URAC is happy to provide additional information and guidance on the insights we've learned regarding quality of care delivered via technology.

Pharmacists Providing Services Incident to Physicians' Services

We appreciate the clarity CMS has provided in response to questions regarding the definition of pharmacists as auxiliary providers who may bill for services incident to physicians' services. This is important clarity given the role pharmacists have played on the front lines of responding to the COVID-19 pandemic and their vital role ensuring patients continue to have appropriate care they require to manage medications prescribed to them.

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