CMS Response to Public Comments Received for CMS-10261

The Centers for Medicare and Medicaid Services (CMS) received comments from Medicare Advantage Organizations related to CMS-10261. This is the reconciliation of the comments.

Comment:

Data Element A: Does your organization offer Telehealth as either as a standard benefit or through a demonstration?

"Yes" or "No" Comment: If our organization offers Telehealth as a supplemental benefit would "Yes" be the appropriate response here?

Response:

Yes, Telehealth offered as supplemental benefit should be captured under Element A.

Comment:

Data Element A. "Does your organization offer Telehealth either as a standard benefit or through a demonstration? 'Yes' or 'No,' only.

Request that CMS clarify whether responses related to the offering of Telehealth "as a standard benefit" should only take into account the "additional" Telehealth benefits MA organizations may (but are not required to) offer and treat as part of the MA basic benefit starting in CY 2020, or whether the agency also intends for organizations to consider the Telehealth benefits that MA organizations are required to cover as part of the basic benefit (i.e., Telehealth benefits covered under Fee-for-Service (FFS) Medicare)."

Response:

Thank you for your comment. We have provided additional clarification for Element A in Element B. Plans should only capture data for providers offering additional Telehealth benefits.

Comment:

Data Element C

The specific information CMS is requesting MA organizations to report Data Element C is unclear. For example, the first sentence references the reporting of the county and state for each applicable Telehealth specialty, and the second sentence references the reporting of state and county data for an applicable Telehealth provider. We recommend that CMS further clarify this Data Element during the subsequent 30-day comment opportunity and provide explicit instructions in the related Part C Technical Specifications document.

Response:

Thank you for your comment. If the provider serves enrollees in different counties, the provider should be listed multiple times. CMS will provide additional guidance in the technical specifications.

Comment:

Data Element D: Total number of contracted Telehealth Providers per contract: Enter____

Would CMS be requesting the number of contracted Telehealth Providers at the individual provider / physician / clinician level (i.e. NPI level) or at the contract level (i.e. Tax ID# level). Appendix 1 of the Contract Year 2019 Medicare Part C Plan Technical Specifications included clarification as to how providers would be counted for purposes of the Payments to Providers Part C reporting requirements. Specifically, FAQ #4 on page 38 of this document indicated that providers were to be reported by contracts. FAQ #4 on page 38 stated that if a plan is in a contract with a provider group, the provider group counts as one contracted provider. If the plan is in a contract with an individual provider, the individual provider counts as one contracted provider. Would the same guidance apply to how Telehealth Providers are contracted?

Response:

Thank you for your comment. If you are referring to the FAQ provided for "Section VII Payment To Providers", the responses provided does not apply to the Telehealth reporting section. The Telehealth reporting section requests plans report at the contract level.

Comment:

Data Element E. Total number of contracted in-person providers for this Specialty in this particular country and State. Enter___

Would CMS be requesting the number of contracted in-person providers in our network that are not Telehealth Providers for each Specialty, county and state that we offer under Telehealth? For example, if our plan offers general medical, dermatology and mental health services under Telehealth in select counties, is CMS requesting that our plan provide a count of the number of contracted providers in our network in those same counties for each specialty (general medical, dermatology and mental health) who provide these services in the office setting?

Response:

Thank you for your comment. Element E captures telehealth providers as a sub-set of Element B.

Comment:

Data Element F: How many of these contracted providers offer both in-person and Telehealth within the same contract? Enter____

Would the number entered in Element Number F be the sum of Element Number D plus Element Number E? Or would the number entered in Element Number F represent the subset of the number of contracted Telehealth Providers entered in Element Number D who also provide in-person services?

Response:

No, Element F will not equal the sum of Elements D and E. Element F captures a sub-set of Element E. – Additional clarification will be provided in the Technical Specifications

Comment:

Additional Guidance.

CMS indicates that the agency intends to issue guidance this summer, during the subsequent 30-day comment opportunity, regarding the list of telehealth specialties that plans will be required to report. We look forward the additional guidance, (i.e., whether there are specific instructions for reporting when organizations contract with telehealth vendors to provide these benefits, etc.). We recommend that the agency ensure that other relevant guidance, such as the MA Network Adequacy Requirements, is updated (as appropriate) to incorporate any key Telehealth-related clarifications that are included in the Part C Reporting Requirements for consistency.

Response:

Thank you for your comment, however this is out of the scope of this PRA.

Comment:

Urge CMS to limit data collection and submission requirements to only those that are necessary. Duplicative and/or burdensome reporting of data and information could dissuade MAOs from making additional telehealth benefits as available as intended by Congress and anticipated by CMS. Also, MAOs may choose to provide access to telehealth benefits very differently based on their existing network structure and care delivery models. For example, a plan may contract with a single vendor to provider all telehealth services across the service area, whereas other plans may choose to cover telehealth services provided by their existing network providers. Plans that leverage their existing network could, therefore, have a significantly heavier reporting burden, depending on how many different providers and specialties are available via telehealth. We believe this factor also weighs in favor of relying on encounter data rather than requiring duplicative reporting by MAOs.

Response:

Thank you for your comment, however this is out of the scope of this PRA.

Comment:

Number of Providers vs. Use of Telehealth Services

We understand importance of knowing the number of MAOs offering additional telehealth benefits. We are concerned, however, that the proposed data elements will not adequately demonstrate the increased access achieved through expanded telehealth offerings, and the data elements will be duplicative of data that CMS will already have access to through other submissions. The data elements CMS proposes would measure only the number of available telehealth providers and not actual enrollee use of telehealth services. In order to measure enrollee access to telehealth services, we believe it is not useful to measure the number of telehealth vs. the number of in-person providers by specialty. Rather, CMS should rely on encounter data in which MAOs report the site of service for a given encounter, including those performed via telehealth.

Comment:

Thank you for your comment, however this comment is out of the scope of this PRA.

County-Level Reporting

We recommend that CMS not require reporting at the county level. Because telehealth services are delivered through electronic means without geographic limitation, we question the value of reporting at the county level. We also believe the county-based reporting would be overly burdensome.

First, the current structure of the reporting requirement suggests that each provider may be limited based on a geographic coverage area, which is not consistent with how telehealth services are provided. While state boundaries have significance for providing telehealth (due to licensure requirements) we are not aware of county-based limitations on telehealth. Additionally, the proposed requirement to report telehealth providers based on county seems duplicative of the PBP filing, which requires that plans indicate which specific services will be offered via telehealth. When filing a telehealth offering in the PBP, a plan must commit to offering it across the entire service area. Thus, based on current filing requirements, CMS already has line of sight into which services are offered via telehealth by service area so there does not appear to be a need for plans to separately report the telehealth specialties offered. Finally, the proposed structure of the reporting requirement is overly cumbersome, as it requires plans to report each specialty at the state and county level, resulting in numerous entries. If CMS proceeds with this data element, we encourage CMS to instead allow plans to indicate which telehealth services are offered and whether they are available across the entire service area."

Response:

Thank you for your comment. However, CMS intends to utilize county level data for purposes, the reporting requirement does not limit the reporting of telehealth providers on geographic coverage area as Element D instructs plans that if "a Telehealth provider serves enrollees from multiple counties in the service area, then count the provider multiple times with the appropriate state and county".

Comment:

Use of Telehealth Services in Network Adequacy Measurement

CMS' current approach to regulating MA provider networks, primarily through geographic time and distance standards, is more strict and rigid than necessary to achieve the intent of the access regulations, provides little assurance that care and covered services are actually accessible to health plan enrollees when they are needed, and does not acknowledge that care is increasingly being provided outside of traditional health care settings.
The current approach of permitting inclusion of telehealth only in the context of exception requests is discouraging to plans that wish to extend access to high-quality, convenient care using telehealth.

To help deliver on its goal of meaningfully assessing the availability and accessibility of health plans' provider networks, we have recommended that CMS undertake a full evaluation of network adequacy measurement options, including the incorporation of telehealth into the network adequacy review framework. We strongly support the availability of telehealth services throughout a plan service area as a mechanism for increased flexibility with respect to network adequacy. Plans that can demonstrate broad and meaningful access to covered services via remote technologies should be permitted to reflect such access in their formal provider network data submissions to CMS.

Response:

Thank you for your comment. However, this comment is out of the scope of this PRA.

Comment:

Will the reporting of telehealth services be a new reporting section or will it be included as element of an existing reporting section (i.e., ODRs)?

Response:

The Telehealth section of the Reporting Requirements is a standalone section.

Comment:

Will the data be corresponding to year 2020 and the report will be submitted 2021?

Response:

Plans are expected to submit first quarter data for CY 2020 on the last Monday of June CY 2020. The remaining quarter's data in CY 2020 should be submitted on the last Monday of February CY 2021.

Comment:

If it is decided to include this new report as part of the reporting requirements, please provide a very clear definition of all the elements requested.

Response:

Thank you for your comment, we have revised Element B to clarify that the following Elements (C-G) should only capture additional Telehealth benefits.