Kaiser Permanente Comments on CMS-10261:
Part C Medicare Advantage Reporting Requirements
and Supporting Regulations in 42 CFR 422.516(a)

Kaiser Permanente appreciates CMS' approach to implementation of "additional telehealth benefits" for Medicare Advantage pursuant to the Bipartisan Budget Act of 2018. We believe the flexible approach will help MAOs to leverage a variety of telehealth technologies to enhance care and ease of access for enrollees. We appreciate CMS' consideration of the following comments on the proposed telehealth reporting requirements.

Purpose of Data Collection; Reporting Burden

According to the supporting materials—

> The data collected in this measure will provide CMS with a better understanding of the number of organizations utilizing Telehealth per contract and to also capture those specialties used for both in-person and Telehealth. This data will allow CMS to improve its policy and process surrounding Telehealth.
>
> In addition, the specialist and facility data we are collecting aligns with some of the provider and facility specialty types that organizations are required to include in their networks and to submit on their HSD tables in the Network Management Module in HPMS.

While we understand the need to report data to assist with CMS monitoring and compliance efforts, we urge CMS to limit data collection and submission requirements to those that are truly necessary to achieve CMS' intent. 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.

It is also important to note that 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.

Number of Providers vs. Use of Telehealth Services

We agree that it is important to understand the number of MAOs and contracts that are making additional telehealth benefits available to their enrollees. However, we are concerned 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.

County-Level Reporting

For several reasons, 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.

Use of Telehealth Services in Network Adequacy Measurement

As we have discussed with CMS staff, 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. Furthermore, 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.

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We appreciate CMS' consideration of these comments. If there are any questions, please contact Jamie Brandi, Executive Director, Medicare Compliance at (510) 271-6933 or Jamie.L.Brandi@kp.org.