



December 28, 2020

Honorable Alex M. Azar II  
Secretary  
U.S. Department of Health & Human Services  
200 Independence Avenue, S.W  
Washington, DC 20201

**RE: Regulatory Relief to Support Economic Recovery; Request for Information (RFI)**

Dear Secretary Azar:

The Alliance for Connected Care (“the Alliance”) appreciates the opportunity to comment in response to the HHS request for information on the health and economic emergency created by the COVID-19 pandemic pursuant to Executive Order 13924, *Regulatory Relief To Support Economic Recovery*, 85 FR 31353 (May 19, 2020). We also laud the U.S. Department of Health and Human Services (HHS) continued leadership in recognizing the value of telehealth and remote patient monitoring in responding to the COVID-19 public health emergency (PHE) and its prompt and continued efforts to ensure access to care during the PHE and beyond.

The Alliance is dedicated to creating a statutory and regulatory environment in which insurers and providers can deliver, and be compensated for providing safe, high quality care using connected care technology. Our members are leading health care and technology companies from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance works in partnership with an Advisory Board of more than 30 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

We were pleased to see the HHS inclusion of additional telehealth services as part of the Medicare Telehealth Services List under the Medicare Physician Fee Schedule, the facilitation of greater telehealth access in home health, and other permanent changes made in recognition of the “new normal” that will include greater telehealth utilization during and after the COVID-19 Public Health Emergency.

Below, we have responded to a number of recent policy changes with recommendations. We believe some should become permanent and some were only appropriate during the PHE and should cease at its end.

**3 Application of OIG's Administrative Enforcement Authorities to Arrangements Directly Connected to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency**

*OIG is accepting inquiries from the health care community regarding the application of OIG's administrative enforcement authorities, including the Federal anti-kickback statute and civil monetary penalty (CMP) provision prohibiting inducements to beneficiaries. On this website, OIG responds to fact-specific inquiries regarding arrangements that are directly connected to the public health emergency and implicate these authorities.*



The Alliance appreciates HHS OIG’s recent rulemaking, which created additional long-term flexibility for telehealth services through the finalization of beneficiary inducement rules for in-home dialysis, extended flexibility for value-based enterprise participants, and created new safe-harbors for digital health tools. We believe that HHS can leverage the data and learnings from the PHE to initiate further changes. Specifically, we recommend that OIG consider allowing the waiving of cost-sharing on beneficiary engagement tools. As digital health technology becomes more ubiquitous, waivers are less likely to create a beneficiary inducement issue. For example – the relatively influence a subsidized tablet or smartwatch might have on a beneficiary behavior diminishes as these items become cheaper and more common. We need to look beyond this, and focus on barriers to patient access and utilization of care, and how we can lower them. Increased patient engagement is critical to the overall economic imperative of increasing value and reducing growth in healthcare costs.

#### **4-5 Notification of Enforcement Discretion for Telehealth Remote Communications**

*Exercise of enforcement discretion to not impose penalties for HIPAA violations against healthcare providers in connection with their good faith provision of telehealth using remote communication technologies during the COVID-19 nationwide public health emergency. Exercise of enforcement discretion to not impose penalties for HIPAA violations against healthcare providers in connection with their good faith provision of telehealth using remote communication technologies during the COVID-19 nationwide public health emergency.*

As reported by the Task Force on Telehealth, the Alliance for Connected Care believes that HIPAA flexibility has been an important step during the rapid expansion of telehealth services during the PHE, but does not believe this flexibility needs to continue beyond the PHE. Healthcare providers, telehealth and EHR vendors, and patients will have had the time to understand and communicate in ways that meet HIPAA privacy and security requirements. That said, HIPAA should never be a barrier to patient care – if there continue to be circumstances in which patients or small providers are not able to utilize secure platforms, or if is the patient’s wish not to do so – narrow exceptions should be made to facilitate access to care.

#### **111 Communication Technology-Based Services (CTBBS)**

*Medicare routinely pays for many kinds of services that are furnished via telecommunications technology (83 FR 59482), but are not considered Medicare telehealth services. These communication technology-based services (CTBS) include, for example, certain kinds of remote patient monitoring (either as separate services or as parts of bundled services), and interpretations of diagnostic tests when furnished remotely. In the context of the PHE for the COVID-19 pandemic, when brief communications with practitioners and other non-face-to-face services might mitigate the need for an in-person visit that could represent an exposure risk for vulnerable patients, we believe that these services should be available to as large a population of Medicare beneficiaries as possible. During the PHE for the COVID-19 pandemic, we are finalizing that these services, which may only be reported if they do not result in a visit, including a telehealth visit, can be furnished to both new and established patients. Consent to receive these services can be documented by auxiliary staff under general supervision. We are finalizing on an interim basis during the PHE for the COVID-19 pandemic that, while consent to receive these services must be obtained annually, it may be obtained at the same time that a service is furnished. We are re-emphasizing that this consent may be obtained by auxiliary staff under general supervision, as well as by the billing practitioner. In the context of the PHE for the COVID-19 pandemic, where communications with practitioners might*



*mitigate the need for an in-person visit that could represent an exposure risk for vulnerable patients, we do not believe the limitation of these services to established patients is warranted. While some of the code descriptors refer to “established patient,” during the PHE, we are exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors. We will not conduct review to consider whether those services were furnished to established patients. On an interim basis, during the PHE for the COVID-19 pandemic, we are also broadening the availability of HCPCS codes G2010 and G2012 that describe remote evaluation of patient images/video and virtual check-ins. We recognize that in the context of the PHE for the COVID-19 pandemic, practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists might also utilize virtual check-ins and remote evaluations instead of other, in-person services within the relevant Medicare benefit to facilitate the best available appropriate care while mitigating exposure risks. We note that this is not an exhaustive list and we are seeking input on other kinds of practitioners who might be furnishing these kinds of services as part of the Medicare services they furnish in the context of the PHE for the COVID-19 pandemic. To facilitate billing of the CTBS services by therapists for the reasons described above, we are designating HCPCS codes G2010, G2012, G2061, G2062, or G2063 as CTBS “sometimes therapy” services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services. CTBS therapy services include those furnished to a new or established patients that the occupational therapist, physical therapist, and speech-language pathologist practitioner is currently treating under a plan of care.*

The Alliance applauds CMS for many positive changes to remote patient monitoring and communication-technology based services during the PHE. The Alliance is broadly supportive of all CMS efforts to facilitate the delivery of telehealth and remote patient monitoring services by all types of healthcare practitioners within the scope of that practitioner’s expertise. We also strongly support continued allowance for consent to be obtained at the time services are furnished on a permanent basis.

The Alliance continues to believe that restrictions on payment for virtual-check-ins based on visits in the previous 7 days or following 24 hours to be a significant limitation on the utility of these services that should be permanently removed. While these visits should not be billed when they would represent unnecessary utilization, the burden of tracking past and future visits does not happen before billing. Rather than risking a false claim over \$14, providers just choose not to utilize virtual check-ins. There may also be clinically appropriate circumstances in which a virtual-check in could be used within 7 days of another medical procedure – and be a better value to the Medicare program than the visit which might be billed instead. These codes need to be changed in order to have real utility.

### **112 Direct Supervision by Interactive Telecommunications Technology**

*For the duration of the PHE for the COVID-19 pandemic, for purposes of limiting exposure to COVID-19, we adopted an interim final policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology (85 FR 19245). We recognized that in some cases, the physical proximity of the physician or practitioner might present additional infection exposure risk to the patient and/or practitioner.*

For the duration of the PHE for the COVID-19 pandemic, CMS adopted an interim final policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner



using interactive audio/video real-time communications technology. The Alliance for Connected Care encourages the permanent extension of this policy, in recognition of the significant workforce changes enacted during COVID-19 that are affecting every industry – not just healthcare. Just as major corporations are adjusting to enable more flexible and remote workforces – healthcare organizations must also evolve. Remote supervision is a critical tool to extend the capability of the healthcare workforce and drive value across the healthcare system in the long-term.

### **113 Telephone Evaluation and Management (E/M) Services Codes**

*We are finalizing, on an interim basis for the duration of the PHE for the COVID-19 pandemic, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443. For these codes, we are finalizing on an interim basis for the duration of the PHE for the COVID-19 pandemic, work RVUs as recommended by the AMA Health Care Professionals Advisory Committee (HCPAC), and work RVUs as recommended by the AMA Relative Value Scale Update Committee (RUC). We are finalizing the HCPAC and RUC-recommended direct PE inputs which consist of 3 minutes of post-service RN/LPN/MTA clinical labor time for each code. Similar to the CTBS described in section II.D. of this IFC, we believe it is important during the PHE to extend these services to both new and established patients. While some of the code descriptors refer to “established patient,” during the PHE we are exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors. Specifically, we will not conduct review to consider whether those services were furnished to established patients. CPT codes 98966-98968 described assessment and management services performed by practitioners who cannot separately bill for E/Ms. We are noting that these services may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners. To facilitate billing of these services by therapists, we are designating CPT codes 98966-98968 as CTBS “sometimes therapy” services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services.*

The Alliance believes that audio-only telehealth has been a critical tool for many clinicians and patients during COVID-19. While we believe that audio-visual communication is the preferred modality for most telehealth, we strongly support continued flexibility for audio-only – when clinically appropriate and the meeting the need or request of the patient. These needs could include technology or broadband limitations or be limited to specific services (such as behavioral health) for which audio-only is demonstrated to be a clinically appropriate means of care delivery. The Alliance supports the addition of payment for audio-only visits, when a two-way, audio/video communication cannot be properly established. The Alliance would support the development of telephone-only payment codes for a specific set of clinically appropriate services if statutory barriers continue to be interpreted to prohibit a more flexible “as-needed and appropriate” approach.

### **115 Use of Telecommunications Technology Under the Medicare Home Health Benefit**

*For the duration of the PHE for the COVID-19 pandemic, we are amending the hospice regulations at 42 CFR 418.204 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' terminal illness and related conditions without jeopardizing the patients' health or the health of those who are providing such services during the PHE for the COVID-19 pandemic.*



*To appropriately recognize the role of technology in furnishing services under the hospice benefit, the use of such technology must be included on the plan of care. The inclusion of technology on the plan of care must continue to meet the requirements at § 418.56, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the measurable outcomes that the hospice anticipates will occur as a result of implementing the plan of care. There is no payment beyond the per diem amount for the use of technology in providing services under the hospice benefit. For the purposes of the hospice claim submission, only in-person visits (with the exception of social work telephone calls) should be reported on the claim. However, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as “other patient care services” using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as “PHE for COVID-19”.*

The Alliance applauds HHS for making permanent some telehealth provisions for home health. We believe that the future of home health will be a synergy of technology-enabled and hands-on care. These types of flexibilities will expand the capacity of our healthcare workforce, and should yield economic benefits by reducing costs for home-based care.

#### **116 Use of Telecommunications Technology Under the Medicare Hospice Benefit**

*For the duration of the PHE for the COVID-19 pandemic, we are amending the hospice regulations at 42 CFR 418.204 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' terminal illness and related conditions without jeopardizing the patients' health or the health of those who are providing such services during the PHE for the COVID-19 pandemic. To appropriately recognize the role of technology in furnishing services under the hospice benefit, the use of such technology must be included on the plan of care. The inclusion of technology on the plan of care must continue to meet the requirements at § 418.56, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the measurable outcomes that the hospice anticipates will occur as a result of implementing the plan of care. There is no payment beyond the per diem amount for the use of technology in providing services under the hospice benefit. For the purposes of the hospice claim submission, only in-person visits (with the exception of social work telephone calls) should be reported on the claim. However, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as “other patient care services” using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as “PHE for COVID-19”.*

The Alliance believes that continued flexibility for telehealth services, “if it is feasible and appropriate to do so” should continue after the PHE. We need to create flexibility for new, high-value care models that leverage technology while maintaining oversight to ensure care is clinically equivalent.

#### **118 Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital**

*Understanding that our current policy may inhibit use of capacity in settings that might otherwise be effective in the efforts to mitigate the impact of the pandemic on Medicare beneficiaries and the American public, we are changing our arrangements policy during the PHE for the COVID-19 pandemic so that*



*hospitals are allowed broader flexibilities to furnish inpatient services, including routine services outside the hospital. We are changing our under arrangements policy during the PHE for the COVID-19 pandemic beginning March 1, 2020, so that hospitals are allowed broader flexibilities to furnish inpatient services, including routine services outside the hospital. Hospitals would be treating patients in locations outside the hospital for a variety of reasons, including limited beds and/or limited specialized equipment such as ventilators, and for a limited time period. While we are changing our under arrangements policy during the PHE for the COVID-19 pandemic to allow hospitals broader flexibilities in furnishing inpatient services, we emphasize that we are not changing our policy that a hospital needs to exercise sufficient control and responsibility over the use of hospital resources in treating patients, as discussed in the FY 2012 IPPS/LTCH PPS final rule and Section 10.3 of Chapter 5 of the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01). Nothing in the current PHE for the COVID-19 pandemic has changed our policy or thinking with respect to this issue and we are making no modifications to this aspect of the policy. Hospitals need to continue to exercise sufficient control and responsibility over the use of hospital resources in treating patients regardless of whether that treatment occurs in the hospital or outside the hospital under arrangements. If a hospital cannot exercise sufficient control and responsibility over the use of hospital resources in treating patients outside the hospital under arrangements, the hospital should not provide those services outside the hospital under arrangements.*

While we believe not all hospital flexibilities should continue after the PHE (since many are specific to the PHE) we can continue to leverage some telehealth and “hospital without walls” or “hospital at home” type flexibilities to drive higher-value care that allows beneficiaries to stay in their homes after the PHE ends. We urge HHS to examine data collected during the PHE to help determine which services may be most appropriate or yield the most health and economic benefit.

#### **121 Requirements for Opioid Treatment Programs (OTP)**

*In light of the PHE for the COVID-19 pandemic, during which the public has been instructed to practice self-isolation or social distancing, and because interactive audio-video communication technology may not be available to all beneficiaries, we are revising § 410.67(b)(3) and (4) to allow the therapy and counseling portions of the weekly bundles, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology during the PHE for the COVID-19 pandemic if beneficiaries do not have access to two-way audio/video communications technology, provided all other applicable requirements are met.*

The opioid crisis will continue after the PHE. Anything that expands access to care for those in need of opioid treatment programs should continue to ensure access to that care. As you know, the opioid crisis has hit many areas of the nation with limited broadband infrastructure – and audio-only care should be available for these individuals in particular.

#### **123 Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) Telehealth**

*Allow Professionals working at Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs) to furnish telehealth services. We are expanding the services that can be included in the payment for HCPCS code G0071, and update payment rates of other codes. We are finalizing that all virtual communication services that are billable using HCPCS code G0071 will also be available to new patients that have not been seen in the RHC or FQHC within the previous 12 months. Also, in situations where obtaining prior*



*beneficiary consent would interfere with the timely provision of these services, or the timely provision of the monthly care management services, during the PHE for the COVID-19 pandemic consent can be obtained when the services are furnished instead of prior to the service being furnished, but must be obtained before the services are billed. We will also allow patient consent to be acquired by staff under the general supervision of the RHC or FQHC practitioner for the virtual communication and monthly care management codes during the PHE for the COVID-19 pandemic.*

### **125 Payment for Medicare Telehealth Services Under Section 1834(m) of the Act**

*To facilitate the use of telecommunications technology as a safe substitute for in-person services, we are, on an interim basis, adding many services to the list of eligible Medicare telehealth services, eliminating frequency limitations and other requirements associated with particular services furnished via telehealth, and clarifying several payment rules that apply to other services that are furnished using telecommunications technologies that can reduce exposure risks. The list of telehealth services, including the additions described later in this section, can be located on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.*

The Alliance for Connected Care generally supports continued access to telehealth services currently being utilized under the PHE. We recognize that additional analysis of codes and utilization during the PHE should help support final determinations on specific codes and appropriate payments.

As mentioned in our Physician Fee Schedule comments, there are a number of priority codes left out of previous COVID-19 PHE actions that are needed by patient populations represented on the Alliance for Connected Care's Advisory Board. We recommend that CMS act to add the following codes during the PHE.

- 92526 (treatment of swallowing dysfunction and/or oral function for feeding)
- 92607 (evaluation for speech generating device; first hour)
- 92608 (evaluation for speech generating device; each additional 30 minutes)
- 92609 (therapeutic services w/ speech generating device includes programming/modification)
- 92610 (evaluation of oral and pharyngeal swallowing function)

Other priority areas for category 3 codes include psychiatric and neuropsychiatric testing, end-stage renal disease, radiation treatment management, and intensive care services.

### **139 Medicare Shared Savings Programs**

*We are modifying Shared Savings Program policies to: (1) Allow ACOs whose current agreement periods expire on December 31, 2020, the option to extend their existing agreement period by 1-year, and allow ACOs in the BASIC track's glide path the option to elect to maintain their current level of participation for PY 2021; (2) clarify the applicability of the program's extreme and uncontrollable circumstances policy to mitigate shared losses for the period of the COVID-19 PHE; (3) adjust program calculations to mitigate the impact of COVID-19 on ACOs; and (4) expand the definition of primary care services for purposes of determining beneficiary assignment to include telehealth codes for virtual check-ins, e-visits, and telephonic communication. We are revising our policies under the Shared Savings Program to exclude from Shared Savings Program calculations all Parts A and B FFS payment amounts for an episode of care for treatment of COVID-19, triggered by an inpatient service, and as specified on Parts A and B claims with dates of service during the episode. We are relying on our authority under section 1899(d)(1)(B)(ii) of the*



*Act to adjust benchmark expenditures for other factors in order to remove COVID-19-related expenditures from the determination of benchmark expenditures. As discussed elsewhere in this section, we are also exercising our authority under section 1899(i)(3) of the Act to apply this adjustment to certain other program calculations, including the determination of performance year expenditures.*

CMS should keep, and expand further, all telehealth flexibility in the Medicare Shared Savings Program. While CMS needs additional statutory authority for many permanent telehealth policies, it has broad authority over alternative payment models. The Alliance was pleased to see CMS take steps to expand flexibility for telehealth in Medicare Advantage plans earlier this year. CMS now has a significant opportunity to facilitate telehealth under Medicare Shared Savings Program (MSSP) and Center for Medicare and Medicaid Innovation (CMMI) models where it has broad statutory latitude. When a health organization agrees to take both financial and health outcome responsibility for patients, they should be allowed by CMS to provide care in a way that best serves their patients. CMS should provide participants in alternative payment models access to an expansive set of telehealth waivers – including waiving geographic and originating site restrictions, patient cost-sharing, additional modalities like telephone-only, supervision allowances, waivers on the frequency of telehealth visits, and rules around covered services, such as those with in-person care requirements. CMS should also seek to eliminate unnecessary telehealth barriers, such as Accountable Care Organization (ACO) restrictions on retrospective assignment.

#### **141 Furnishing Hospital Outpatient Services Remotely**

*Hospital and CMHC staff can furnish certain outpatient therapy, counseling, and educational services (including PHP services) incident to a physician's service during the COVID-19 PHE to a beneficiary in their home or other temporary expansion location using telecommunications technology. In these circumstances, the hospital can furnish services to a beneficiary in a temporary expansion location (including the beneficiary's home) if that beneficiary is registered as an outpatient; and the CMHC can furnish services in an expanded CMHC (including the beneficiary's home) to a beneficiary who is registered as an outpatient. We also clarified that hospitals can furnish clinical staff services (for example, drug administration) in the patient's home, which is considered provider-based to the hospital during the COVID-19 PHE, and to bill and be paid for these services when the patient is registered as a hospital outpatient. Further, we clarified that when a patient is receiving a professional service via telehealth in a location that is considered a hospital PBD, and the patient is a registered outpatient of the hospital, the hospital in which the patient is registered may bill the originating site facility fee for the service. Finally, we clarified the applicability of section 603 of the BBA 2015 to hospitals furnishing care in the beneficiaries' homes (or other temporary expansion locations), and whether those locations are considered relocated, partially relocated, or new PBDs.*

As noted with regard to inpatient services, we believe that we can continue to leverage some telehealth and “hospital without walls” or “hospital at home” type flexibilities to drive higher-value care that allows beneficiaries to stay in their homes after the PHE ends. We urge HHS to examine data collected during the PHE to help determine which services may be most appropriate or yield the most health and economic benefit.

#### **143 Payment for Remote Physiologic Monitoring (RPM) Services**





*We are establishing a policy on an interim final basis for the duration of the COVID-19 PHE to allow RPM codes to be billed for a minimum of 2 days of data collection over a 30-day period, rather than the required 16 days of data collection over a 30-day period as provided in the CPT code descriptors.*

In the current CPT code explanatory language for CPT Codes 99453 & 99454 there is a requirement that, in order to bill these codes, the patient must have monitoring devices in use for at least 16 days in a 30-day period. CMS temporarily waived this requirement for those with a COVID-19 or suspected COVID-19 exposure. While this requirement is likely valid for the appropriate tracking and treatment of many chronic conditions, COVID-19 has highlighted the benefit of using RPM for acute conditions as well. In the proposed rule, CMS asks for input on removing the 16-day requirement despite the inclusion in the CPT code explanatory language. We believe that CMS should adopt distinct codes for RPM services for acute conditions and RPM services for chronic conditions; however, in the meantime, we urge CMS to remove the 16-day requirement from CPT Codes 99453 & 99454.

#### **149 Updating the Medicare Telehealth List on a Sub-regulatory Basis**

*Due to the urgency of minimizing unnecessary contact between beneficiaries and practitioners, we believe that, for purposes of the PHE for the COVID-19 pandemic, we should modify the process we established for adding or deleting services from the Medicare telehealth services list under our regulation at § 410.78(f) to allow for an expedited process during the PHE that does not involve notice and comment rulemaking. Therefore, for the duration of the PHE for the COVID-19 pandemic, we are revising our regulation at § 410.78(f) to specify that, during a PHE, as defined in § 400.200 of this chapter, we will use a subregulatory process to modify the services included on the Medicare telehealth list. While we are not codifying a specific process to be in effect during the PHE for the COVID-19 pandemic, we note that we could add services to the Medicare telehealth list on a subregulatory basis by posting new services to the web listing of telehealth services when the agency receives a request to add (or identifies through internal review) a service that can be furnished in full, as described by the relevant code, by a distant site practitioner to a beneficiary in a manner that is similar to the in-person service. We also note that any additional services added using the revised process would remain on the list only during the PHE for the COVID-19 pandemic.*

The Alliance has supported this flexibility during the PHE. More important than additions to the telehealth list is the process for potential removals from the list at the end of the PHE. CMS should be making additional permanent changes within its authority, even if those changes may require revision at a future date. CMS should also aggressively leverage a much wider set of its fee-schedule declared “category 3 codes” to help create a smoother, calendar year-aligned, “off-ramp” for those services which may not continue – rather than having an abrupt and unpredictable ending with the close of the public health emergency. It would make the most sense and create the least administrative burden on the health system for CMS to attempt to smoothly transition from public health emergency-approved codes to physician-fee-schedule codes without significant changes (recognizing that CMS can only make these changes on some flexibilities).

#### **189 Allow use of audio-only equipment to furnish audio-only telephone E/M, counseling, and educational services**

*Pursuant to authority granted under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver*



*allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services (see designated codes <https://www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/Telehealth-Codes>). Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.*

Previous remarks from the Alliance for Connected care on audio-only telehealth apply here as well. Audio should be allowed for a limited set of clinically appropriate services, or when a video visit requirement would restrict patient access.

### **201 Practitioner Locations**

*42 CFR 424.510 (d)(2)(III)(A). CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met: (1) Must be enrolled as such in the Medicare program; (2) must possess a valid license to practice in the state, which relates to his or her Medicare enrollment; (3) is furnishing services—whether in person or via telehealth—in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and, (4) is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area. In addition to the statutory limitations that apply to 1135-based licensure waivers, an 1135 waiver, when granted by CMS, does not have the effect of waiving state or local licensure requirements or any requirement specified by the state or a local government as a condition for waiving its licensure requirements. Those requirements would continue to apply unless waived by the state. Therefore, in order for the physician or non-physician practitioner to avail him- or herself of the 1135 waiver under the conditions described above, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state.*

While we recognize this change had little practice impact given that most licensure requirements exist at the state level, we believe CMS should aggressively push forward with the removal of this requirement on a permanent basis. The redundancy with state law is an impediment to state leadership on the reduction of barriers to care across state lines. We strongly support this work and call on CMS to take a permanent step in support of its advancement.

### **210 Remote Patient Monitoring Reporting**

*Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473-99474, 99493-99494).*

The Alliance strongly supports the ability to provide RPM services to new patients and the use of these services for both acute and chronic conditions. As communicated to CMS in our fee schedule comments, we are particularly concerned with recent steps taken by CMS around remote patient monitoring. Specifically, the Alliance does not agree with CMS's interpretation of codes 99457 and 99458 and the



proposed requirement that “interactive communication” consist of real-time synchronous two-way audio. Requiring real-time interaction is inconsistent with the opportunity and intent of remote patient monitoring technologies, which are effectively delivered using a mix of both synchronous and asynchronous modalities.

### **211 Remote Evaluations, Virtual Check-Ins & E-Visits**

*Medicare patients may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. Clinicians can provide remote evaluation of patient video/images and virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. These services were previously limited to established patients. E-visits are non-face-to-face communications with their practitioner by using online patient portals. (HCPCS codes G2061-G2063).*

As communicated to CMS for several years now, restrictions on payment for virtual-check-ins based on visits in the previous seven days or following 24 hours to be significant limitation on the utility of these services. While these visits should not be billed when they would represent unnecessary utilization, the burden of tracking past and future visits does not happen before billing. Rather than risking a false claim over \$14, providers just choose not to utilize virtual check-ins. There may also be clinically appropriate circumstances in which a virtual-check in could be used within seven days of another medical procedure – and be a better value to the Medicare program than the visit which might be billed instead. These codes need to be changed in order to have real utility.

### **215 Eligibility for Telehealth**

*Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.*

While we recognize that a statutory change is needed for CMS to fully implement these changes, we strongly support its permanency. The ability to provide telehealth services should not be different from the ability to provide the same services in-person. If a practitioner has the training and experience to provider a service, they also have the training and experience to provide that service through telehealth.

### **Medicaid SPA -**

*345 Extend Telehealth Utilization - Agency makes changes to telehealth utilization, which may be different than outlined in the state's approved state plan.*



354 Payments for Telehealth Services - *Removing existing state plan language restricting use of telehealth/telephonic delivery of services and paying for such services at either the same face-to-face state plan rates or alternative rates.*

The Alliance for Connected Care encourages CMS to seek alignment between Medicare telehealth services and Medicaid telehealth services wherever and whenever possible. While additional telehealth services are needed in many Medicaid programs, so is greater consistency in what Medicaid covers.

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The Alliance greatly appreciates HHS's leadership in working to ensure that seniors are able to realize the benefits of telehealth and remote patient monitoring. We look forward to continuing to work with you to increase access to high quality connected care for beneficiaries. If you have any additional questions, please do not hesitate to contact Chris Adamec at [cadamec@connectwithcare.org](mailto:cadamec@connectwithcare.org).

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac".