



September 13, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Proposed CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1751-P)

Dear Administrator Brooks-LaSure:

The Alliance for Connected Care (“the Alliance”) welcomes the opportunity to provide feedback on the Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule for calendar year (CY) 2022, which includes several important reforms with respect to telehealth. We appreciate the Centers for Medicare and Medicaid Services’ early recognition of the value of telehealth and remote patient monitoring in responding to the COVID-19 pandemic and its prompt and continued efforts to ensure access to care during the public health emergency 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.

As reflected in the comments below, the Alliance applauds the proposal to retain all Category 3 telehealth codes through the end of Calendar Year (CY) 2023 to provide an opportunity to collect and study data on the telehealth experience during the COVID-19 public health emergency. The Alliance is committed to leveraging telehealth and remote patient monitoring to improve the quality of care while also lowering costs and improving efficiency, and we believe this extension will help to serve all three of those aims.

The Alliance would like to emphasize the following overarching priorities in advance of our more detailed response:



- A great deal of confusion continues to exist around the authority of the Administration to make longer-term telehealth changes. We encourage CMS to continue clearly communicating to Congress and stakeholders that there are statutory limitations curtailing CMS' ability to allow continued access to telehealth for Medicare beneficiaries. Additionally, we urge you to continue collecting and publicly sharing data about telehealth utilization and inform a conversation with Congress around what statutory authorities CMS needs to make thoughtful, long-term policy.
- While we appreciate and support CMS's effort to create temporary category 3 codes and its proposal to retain these codes through the end of the Calendar Year (CY) 2023, we continue to believe these codes are inadequate to the stability and predictability needed for health care providers to make necessary investments and plan for care/care systems in the longer term. Furthermore, and just as important, patients deserve and require predictability in their health care – and we urge CMS to consider patient expectations especially as patients have become more engaged in the delivery of health care services, and have become more ensconced in a hybrid model of health care delivery.
- While we recognize some statutory requirements exist, we remain very concerned with steps taken by CMS around in-person visit requirements. The Alliance and its members strongly believe that an in-person requirement constrains telehealth from helping individuals that are homebound, have transportation challenges, live in underserved areas, etc. It does not constrain those using telehealth for convenience. This creates a perversion of the Medicare payment system by reducing access for those who need it most, while allowing access for others.
- While we are supportive of CMS' proposals to increase beneficiary participation and access in the Medicare Diabetes Prevention Program (MDPP) Expanded Model, we would like to highlight additional actions that would match CMS' goals for the program. Specifically, the Alliance strongly feels that CMS should permit any CDC-recognized DPP suppliers to apply to become Medicare suppliers – including virtual DPP suppliers. Not only would permitting virtual suppliers to apply to become MDPP Expanded Model Suppliers increase the number of MDPP Suppliers participating in the program, but it would also broaden the reach of who can receive diabetes prevention services beyond brick-and-mortar locations, and provide convenient and timely access to a more diverse set of patients no longer burdened by needing to take time off everyday demands to complete the required curriculum.

The telehealth experience during COVID-19 has pushed forward a revolution in access to care for America's seniors – introducing millions to a new way to access health care. Our written comments only begin to capture how crucial the improvement in access to care that America's seniors have experienced



has been and how meaningful it is that telehealth is available to provide access to care when and where appropriate.

Support for Temporarily Retaining Category 3 Codes Until the End of Calendar Year 2023

We applaud CMS's proposal to retain all Category 3 telehealth codes through the end of Calendar Year (CY) 2023 to provide an opportunity to collect and study data on the telehealth experience during the COVID-19 public health emergency. Allowing additional time to collect, study and publish data on telehealth during the PHE is critical to determining which and to what extent specific services have benefited patients.

Several studies have been published thus far on the COVID-19 experience and we encourage CMS to continue to explore these and additional studies as they continue to examine telehealth services for which should be expanded on a permanent basis. In addition to examining the clinical benefit when determining whether to continue certain telehealth services, CMS should take into account efficiencies afforded, such as enhancing access to care by removing transportation, work, childcare and other everyday demands that make it hard to attend an in-person appointment. Furthermore, cost-saving efficiencies should be weighed such as fewer missed appointments, greater adherence to a care plan, and other environmental effects like fewer emissions.

As the Centers for Medicare & Medicaid Services (CMS) have shown, the COVID-19 pandemic has introduced millions of older Americans to a new way to access health care. Preliminary [data](#) from CMS show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the PHE. Throughout the pandemic, multiple sources have confirmed that telehealth is largely a substitute for in-person care – and does not represent an increase in utilization. As in-person care began to resume in May 2020, telehealth visits dropped to 30 percent but there was still no net visit increase. We determine this from data showing that as in-person visits increased, telehealth visits decreased, demonstrating a substitution effect. A [claims-based analysis](#) suggests that approximately \$250 billion in health care spend could be shifted to virtual care in the long term – roughly 20 percent of all Medicare, Medicaid and commercial outpatient, office and home health spend.

The effects of the COVID-19 pandemic on patients seeking or avoiding care has also been analyzed and is discussed in brief below. As has been determined through various studies, telehealth helps to avoid more costly care – and provides patients quicker, more convenient access to their health care providers. First, according to the [COVID-19 Healthcare Coalition survey](#), nearly 80 percent of the more than 2,000 patients surveyed indicated that they received telehealth services from their own provider, demonstrating that more often than not patients can and will get care from their existing provider. Second, and strikingly, approximately 50 percent of patients responded that they would have delayed their care during COVID-



19 percent if telehealth was not an option and 81 percent of patients felt that telehealth provided them with a sense of access and continuity of care.

In addition to the above findings, CMS should consider telehealth's ability to increase efficiencies and improve access where barriers to care exist. COVID-19 has dramatically heightened awareness of existing health disparities and made the call to address these longstanding issues more urgent. Transportation is just one example of a barrier to care that telehealth can alleviate. Transportation barriers are regularly cited as barriers to access, particularly for low-incomes or under/uninsured populations – leading to missed appointments, delayed care, and poor health outcomes. In a 2018 proposed rule, CMS estimated that telemedicine is saving Medicare patients \$60 million in travel time, with a projected estimate of \$100 million by 2024 and \$170 million by 2029. CMS also noted that these estimates tend to underestimate the impacts of telemedicine. Higher projections estimate \$540 million in savings by 2029. We encourage CMS to consider these findings.

Permanent Addition to the Medicare Telehealth Services List

While we support CMS' decision to retain all Category 3 telehealth codes through the end of Calendar Year (CY) 2023, we are disappointed CMS did not find clinical benefit for any of the proposed Category 1 or Category 2 codes. While we find it concerning that none of these codes met CMS' requirements for permanent addition, we appreciate CMS allowing additional time to bring forth data in support of permanent addition of telehealth codes.

Some of the most appropriate codes to be considered for permanent status are the psychological and neuropsychological testing codes 96130-96133. These are clinically effective and successfully leveraged for behavioral health at Alliance member institutions – who have been practicing them regularly.

Remove Restrictions on Medicare Beneficiary Access to Mental and Behavioral Health Services Offered Through Telehealth

We are particularly concerned with steps taken by CMS around in-person visit requirements. The Alliance and its members strongly believe that an in-person requirement constrains telehealth from helping individuals that are homebound, have transportation challenges, live in underserved areas, etc. It does not constrain those using telehealth for convenience. This creates a perversion of the Medicare payment system by reducing access for those who need it most, while allowing access for others.

We support relationship-based care, and we believe that telehealth is an appropriate means to establish a meaningful relationship with a patient – much like telehealth is merely a different modality to providing care. We support CMS' diligence in preventing fraud, waste and abuse in the Medicare program, however as stated, an in-person requirement is never the right guardrail for a telehealth service. We are not alone



in this belief. The Medicare Payment Advisory Commission (MedPAC) recommended in their March, 2021 Report to Congress to require an in-person, face-to-face visit before ordering expensive durable medical equipment (DME). While we do not support in-person requirements, if one was to be added it should only be in response to high-cost prescribing – not related to services. Additionally, if Congress were to change statutory authority, CMS should not require anything more than what Congress has created in statute.

We have several other recommendations that we believe would also greatly deter and catch fraudulent actors and protect the Medicare program and its beneficiaries. In brief, those include: 1) Enhance the ability of HHS to fight fraud in Medicare through new resources and capacity; 2) Work to develop restrictions on solicitation of Medicare beneficiaries in Fee-For-Service by fraudulent actors 3) Work to strengthen the Medicare provider enrollment process; and 4) Utilize enhanced data capabilities present in nearly all telehealth platforms.

In addition to our above comments, we provide comment on several other mental health specific proposals below. Due to the COVID-19 pandemic, we have seen dramatic increases in the demand for telemental health services. To ensure Medicare beneficiaries are able to obtain vital mental health services, we are supportive of the following proposals:

- We are supportive of CMS' proposal to identify the home of a beneficiary as an originating site for telehealth services for the diagnosis, evaluation or treatment of a mental health disorder. The COVID-19 pandemic has clearly demonstrated the need for telehealth in rural areas, in urban areas, at work, at school, at home and many other locations. We believe that the location of the patient should not determine whether a patient can access telehealth services. However, the Alliance continues to believe that "home" is a vague and unenforceable construct, as "home" can mean anything from a patient's physical home, their car, a relative's house, or elsewhere. Therefore, the Alliance believes that "home" should be replaced with "the location of the patient."
- We are supportive of CMS' proposal to specify that the geographic restrictions do not apply to telehealth services furnished for the diagnosis, evaluation or treatment of a mental health disorder. We believe patients should never be limited by their geographic location. The COVID-19 pandemic has taught us that patients living in rural and urban settings benefit from access to telehealth services.

Feedback Regarding Audio-only Telehealth Visit Policies

We are supportive of CMS' proposal to revise the regulatory definition of "interactive telecommunications system" to permit use of audio-only communications technology for mental health telehealth services.



The Alliance believes that audio-only telehealth has been a critical tool for many clinicians and patients during COVID-19, especially when considering providing equitable access to care for patients facing broadband, affordability and other barriers. While we believe that audio-video communication is the preferred modality for most telehealth, we strongly support continued flexibility for audio-only – when clinically appropriate and when meeting the need or request of the patient. We believe that failure to allow audio-only services will result in significant care gaps that disproportionately affect the Medicare population.

Below we outline several additional comments specific to the audio-only proposals:

- While we recognize statutory requirements, we are disappointed in yet another in-person requirement for access to services. The Alliance and its members strongly believe that an in-person requirement constrains telehealth from helping individuals that are homebound, have transportation challenges, live in underserved areas, etc. It does not constrain those using telehealth for convenience. We request CMS refrain from these requirements with the possible exception of requirements prior to the prescribing of specific, costly services such as durable medical equipment (DME).
- While we foresee no problem with the specific criteria limiting payment for audio-only services, we urge caution in how CMS will track and determine whether these criteria are actually being met. For instance, we are concerned that providers and the agency may lack the capabilities to report and track instances in which “the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.” Furthermore, providers are concerned that if they are unable to adequately provide confirmation that these conditions were met, they may be penalized when they are, in fact, not at fault. We urge CMS to reconsider this proposal.
- We are supportive of CMS’ proposal to create a service-level modifier that would identify mental health telehealth services when furnished to a beneficiary in their home using audio-only communications technology. During the pandemic, we’ve witnessed firsthand the benefits of providing access to audio-only services – and as such we feel it necessary that providers can appropriately and confidently bill for these services.

Rural Health Clinics and Federally Qualified Health Centers (and Critical Access Hospitals)

The Alliance supports CMS’ proposals to provide greater flexibility for Federally Qualified Health Centers and Rural Health Clinics to furnish mental health telehealth visits, including via audio-only interactions. Similar to our above comments, we urge caution when placing restrictions on when a provider would be permitted to utilize audio-only. For example, we are concerned that providers and the agency may lack



the capabilities to report and track instances in which beneficiaries “are not capable of, or do not consent to, the use of devices that permit a two-way, audio/video interaction.” Furthermore, providers are concerned that if they are unable to adequately provide confirmation that these conditions were met, they may be penalized when they are, in fact, not at fault.

Second, we are supportive of CMS’ efforts to better track when certain services are utilized. Specifically, we support the use of a 95 modifier in instances where RHCs and FQHCs are furnishing mental health services.

As CMS recognizes through the draft PFS rule, rural behavioral health challenges are both a moral and economic imperative for communities across the nation. Approximately 20 percent of the rural population experiences mental illness and the rural community is disproportionately impacted by the opioid epidemic. Approximately 48,000 people die by suicide every year – the 10th leading cause of death in the United States. These suicide rates were 40 percent higher in rural areas than in large urban areas (and are increasing at a faster rate). This is only made worse by the fact that there is a severe shortage of mental health professionals in rural areas. Over 80 percent of rural counties do not have a psychiatrist, compared to 27 percent of counties in metropolitan areas.

Finally, please note that Critical Access Hospitals (CAHs) are omitted from this list, but are a crucial component of a healthcare system able to reach all Medicare beneficiaries and must be able to directly bill for telehealth services. Outpatient behavioral therapy services offered by Critical Access Hospitals (CAHs) are a key component of a comprehensive rural behavioral health strategy.

We strongly believe that CMS should ensure CAHs, RHCs, FQHCs, and other providers are all equipped to fully leverage telehealth and that they are able to bill for clinically equivalent services the same way they would an in-person service.

Direct Supervision Via Telehealth

CMS has requested comment on the use of telehealth for direct supervision. The Alliance for Connected Care strongly supports the continued use of direct supervision via telehealth. Virtual direct supervision continues to be necessary, both during COVID and beyond to maintain safety and social distancing for care teams while practicing together. It is also incredibly important in the academic medical setting -- to allow adequate educational opportunities for those seeking to grow and strengthen the health care work force. Alliance for Connected Care members report no negative impact on clinical quality from this important modernization of supervision requirements.

Remote Therapeutic Monitoring



The Alliance for Connected Care supports CMS’s rationale and creation of these codes and believe this modality of care could be leveraged broadly across specialties. The ability to monitor non-physiologic data will empower practitioners, strengthen medication adherence, and allow the monitoring of many conditions and treatments.

Virtual Care in the Diabetes Prevention Program

The Alliance believes that one of the most appropriate uses of virtual care is for the management of ongoing chronic conditions. Therefore, we also provide comment on the proposed Medicare Diabetes Prevention Program (MDPP) Expanded Model policies. The Alliance believes that virtual DPP programs have significant promise for ensuring the health of Medicare beneficiaries and should be covered by CMS.

We respectfully request that CMS consider allowing CDC-recognized virtual DPP suppliers to participate in the Medicare Diabetes Prevention Program. Permitting virtual Suppliers to apply to become MDPP Expanded Model Suppliers would increase the number of MDPP Suppliers participating in the program, broaden the reach of who can receive diabetes prevention services beyond brick-and-mortar locations, and provide convenient and timely access to a more diverse set of patients no longer burdened by needing to take time off everyday demands to complete the required curriculum.

We believe that virtual MDPP can be offered to Medicare beneficiaries in a manner that aligns with CMS’s stated goals for the MDPP benefit, and to further ensure that a greater number of Medicare beneficiaries who are eligible for the MDPP benefit can use it to reduce their risk of chronic disease – a crucial step in light of skyrocketing chronic disease challenges during and after the COVID-19 Public Health Emergency.

Additional Guidance Requested

We urge CMS to address provider enrollment concerns and facilitate actions to reduce provider burdens. During the COVID-19 public health emergency, CMS moved to allow practitioners to render telehealth services from their home **without reporting their home address** on their Medicare enrollment while continuing to bill from their currently enrolled location. Unfortunately, this policy is set to expire at the conclusion of the PHE. The current enrollment structure is outdated and does not support providers new operational and privacy concerns faced in a digital age. Furthermore, we encourage thoughtful consideration of the implications of telehealth on providers – not just patients. All of the conveniences that telehealth provides for patients, are also afforded to providers. First, care can be delivered dynamically and in many settings. A provider may not be just at their office, they can be at home, or at an off-site clinic, etc., and there are operational issues with how to list all of those various addresses. In addition, all providers (whether 0%, 51%, or 100% virtual care) are associated with a clinic that has a primary address. The associated address for that clinic represent the “operational structure.” Therefore, the infrastructure has little to do with where the provider is located physically during the virtual visits.



Second, in addition to operational concerns, providers have personal privacy concerns with submitting their personal home addresses. Given that CMS declined to address this issue under rulemaking, we urge examination of these concerns and adoption of appropriate changes as described herein.

The Alliance respectfully requests that CMS provide additional guidance to providers who wish to continue providing services from their home but do not feel comfortable listing their home address.

The Alliance greatly appreciates CMS's leadership in working to ensure that seniors are able to realize the benefits of telehealth and remote patient monitoring. We appreciate the opportunity to provide feedback on the Medicare Physician Fee Schedule (PFS) Proposed Rule for calendar year (CY) 2021, and look forward to continuing to work with CMS to increase access to high quality connected care for Medicare beneficiaries. If you have any additional questions, please do not hesitate to contact Chris Adamec at cadamec@connectwithcare.org.

Sincerely,

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