



September 6, 2022

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: Comments on CY 2023 Physician Fee Schedule Proposed Rule (CMS-1770-P)

Dear Administrator Brooks-LaSure,

The Alliance for Connected Care (“the Alliance”) welcomes the opportunity to provide feedback on the Centers for Medicare & Medicaid Services (“CMS”) Medicare Physician Fee Schedule proposed rule, which updates the schedule for Calendar Year 2023 (CY 2023) and includes several important changes with respect to telehealth. We appreciate your leadership in ensuring continued access to care during the COVID-19 public health emergency (PHE) and beyond.

The Alliance is dedicated to creating a statutory and regulatory environment in which patients can receive and health care organizations can deliver and be compensated for providing coordinated, safe, and 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 40 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 appreciates the proposal to retain all Category 3 telehealth codes through the end of CY 2023 to provide an opportunity to collect and study more 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 quality of care while also lowering costs and improving the clinician experience, 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:

- While we appreciate and support the effort from CMS to create more temporary Category 3 codes (and its proposal to retain these codes through the end of CY 2023), we are disappointed CMS did not find sufficient clinical benefit to add any of the proposed Category 1 or Category 2 codes. We continue to believe these temporary codes do not represent the forward movement on telehealth needed. The Administration should be moving to create the stability and predictability needed for health care providers and patients to plan for future health needs. Additionally, we believe that the lack of forward movement on codes does not align with the significant body of evidence that



has developed around the usage of telehealth services and their impact on quality and patient access.

- While we recognize statutory requirements exist, we remain concerned with steps taken by CMS around in-person visit requirements and we encourage CMS to apply these requirements to the minimum extent required by law. 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, or have other needs. This reduces access for those who need it the most, while allowing access for those capable of in-person care.
- There continues to be a misconception among many that telehealth is separate and different from in-person care. It is not. It was shown during the pandemic that Medicare telehealth services were used simply as a different modality for a patient's existing providers to improve access and maintain continuity of care. Given this evidence, we believe limiting non-facility providers to a lower facility payment rate for telehealth would have the effect of disincentivizing telehealth usage by a patient's existing in-person provider and undermining opportunities to increase patient access.
- We strongly support the continued availability of direct supervision through telehealth. The option for virtual direct supervision has been proven to be a meaningful tool to maintain teams remotely during a public health emergency. However, this expansion of health system capability is needed for more than just public health emergencies – it is also a meaningful tool to meet health care workforce challenges – both in the delivery of care and to grow the workforce through more flexible academic settings.

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 Adding Services to the Category 3 Codes Until the End of Calendar Year 2023

We appreciate the proposal from CMS to retain all Category 3 telehealth codes through the end of CY 2023 to provide an opportunity to collect and study data on the telehealth experience during the COVID-19 PHE. Allowing additional time to collect, study, and publish data on telehealth during the PHE is critical to proving the benefit of these services and to what extent specific services have benefited patients.

The Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the HHS Office of Inspector General (OIG) both released reports that found telehealth was critical for providing services to Medicare beneficiaries during the pandemic. We encourage CMS to explore these and additional studies as they continue to examine telehealth services that should be expanded on a permanent basis. In addition to examining the utilization and clinical benefits when evaluating telehealth services, future research should take into account increases in patient access and efficiencies afforded, such as the removal of transportation, work, childcare, and other everyday barriers to in-person care. Furthermore, broader clinical benefits, such as the number of missed appointments and general adherence to a care plan, should be considered.



As CMS has shown, the COVID-19 pandemic has introduced millions of older Americans to a new way to access health care. [Data from CMS](#) show that between March 2020 to February 2021, over 28 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the COVID-19 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. We determine this from data showing that as in-person visits increased, telehealth visits decreased, demonstrating a substitution effect. Additionally, the HHS OIG released a [report](#) earlier this year which found that telehealth was critical for providing services to Medicare beneficiaries, particularly for behavioral health services (43 percent).

Telehealth can address soaring behavioral health needs, meet patients in their homes, and reduce wait times for patients. According to [a survey of both clinicians and patients](#) conducted by the Alliance for Connected Care, 91 percent of health care practitioners agree that they should continue to have the option to deliver virtual care after the pandemic. Additionally, according to a [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 providers. Finally, and strikingly, approximately 50 percent of patients responded that they would have delayed their care during COVID-19 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. While COVID-19 was a barrier to care, it is not the only one – this delayed care will continue to happen in the future for any number of reasons that could be addressed by telehealth – from anxiety to transportation barriers.

In addition to the above findings, CMS should consider telehealth’s ability to increase efficiencies and improve access where barriers to care exist. The COVID-19 pandemic 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-income 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 Additions to the Medicare Telehealth Services List

While we appreciate the decision made by CMS to retain all Category 3 telehealth codes through the end of CY 2023, we are disappointed CMS did not find sufficient clinical benefit for any of the proposed Category 1 or Category 2 codes. While we understand that not all current telehealth services may continue, we believe that a significant body of evidence has developed around the usage of telehealth services and their impact on quality and patient access. We strongly urge CMS to begin using this data to lay out a clear path forward for these services. Patients and health care providers are looking for clarity and certainty beyond the pandemic and there is no need to wait for the end of the public health emergency to advance the much-needed evaluation of different services through telehealth.



We also believe that the process by which CMS reviews and approves codes for Category 1 or Category 2 status could be improved. It is a time-consuming and costly endeavor to submit codes for consideration, and it could take years to collect adequate data. Without CMS demonstrating that it regularly approves new codes, the cost-benefit analysis of undertaking this effort for health care organizations is difficult.

Additionally, there should not be a need for CMS to specifically evaluate whether providing a service through telehealth adds clinical value, if CMS already knows that the service itself provides clinical value. Telehealth is simply a modality for providing the same care – it is not a different service or type of care. Proving that a service which has already been deemed by CMS to have clinical value a second time is a redundancy and is holding telehealth to a higher standard than other care. The Alliance strongly recommends that CMS consider revising the criteria in a future rulemaking to only require a demonstration that telehealth is an appropriate modality to deliver an already valid service.

We appreciate CMS moving a number of the codes that are currently on the PHE list to the Category 3 telehealth list on a temporary basis through the end of CY 2023 in order to create more certainty and to evaluate them for potential expansion.

While we agree that the preferred method of telehealth for patients is two-way, audio-video communications, we are concerned that CMS is limiting access for those who face barriers to a two-way audio-video platform. We recommend that CMS directly cover the Telephone E/M visit codes rather than bundle the codes to ensure Medicare patients are able to access different avenues of care. Telephone codes have demonstrated benefits – particularly for brief communication technology-based evaluation and management services. Community clinics, for example, have relied on telephone visits for patients who do not have access to video communications. Additionally, [data](#) has shown that age is a factor in audio-only telehealth use, with recent HHS data showing that video telehealth rates were lowest among adults age 65 and older (43.5 percent), with barriers such as lack of access to technology to conduct a video visit, or barriers related to technological literacy, physical disability or cognitive decline, being cited as main factors. As such, CMS should allow Telephone E/M codes to continue to be billed as standalone options in certain circumstances, such as brief communications, for Medicare beneficiaries who require more guidance throughout their care plan.

Implementation of Mental and Behavioral Health Services Offered Through Telehealth with Restrictions on Medicare Beneficiary Access

We thank CMS for implementing the delay of the in-person visit requirements for mental health visits. However, we remain concerned with steps taken by CMS to require in-person visit requirements to a greater extent than the minimum required by statute. While we recognize that there may be some services for which an in-person visit is clinically necessary, this is a decision for the medical provider and the patient. This is particularly true for mental health services, as these services offered through telehealth are generally accepted to be equally effective to those offered in person, with some benefits offered by either modality. According to a 2021 [study](#), approximately 66 percent of all behavioral health care is delivered virtually. In the context of Medicare fee-for-service, we caution that an in-person requirement may disproportionately impact Medicare beneficiaries who have come to rely on virtual care for mental



and behavioral health services, and that this requirement could be detrimental to ongoing continuity of care for such beneficiaries.

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, or experience other barriers to access. It does not constrain those using telehealth for convenience. This creates a perversion of the Medicare payment system by reducing access for those who do not have access to in-person care and need it most, while allowing access for others who have more convenient access to in-person care. We support relationship-based care, and we believe that telehealth is an appropriate means to establish and maintain a meaningful relationship with a patient – as telehealth is merely a different modality to providing care.

Feedback Regarding Audio-only Telehealth

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 telehealth – 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.

The Alliance for Connected Care calls on CMS to immediately begin a public process to collect evidence and evaluate the services most predominantly offered through audio-only telehealth, to better understand its utilization, and collect expert clinician perspectives on what services should continue to have an audio-only option after the end of the PHE.

As discussed below, we are supportive of the proposal by CMS 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. We also believe that these steps will help provide additional clarity to ensure providers are correctly billing for audio-only visits and to ensure there is clear and effective data capture for further analysis of the clinical benefits and outcomes related to these services. However, we caution CMS around the total removal of reimbursement for audio-only modalities for services outside of mental and behavioral health services. We expect that evidence will show additional services where audio-only telehealth can be clinically appropriate, particularly in areas where broadband availability or digital literacy might be limited or not sufficient to support a video visit. This could hamper continuity of care that has been underway telephonically, especially treatment plans begun during the pandemic.

Interim Modifiers for Telehealth Services Transitioning out of the COVID-19 PHE

We thank CMS for providing clarification and guidance on the telehealth services transitioning out of the COVID-19 PHE. Continuing to bill telehealth as it has been during the PHE will allow continuity for health



care providers during the 151 days after the end of the PHE and help to ensure payments are processed properly.

The Alliance appreciates the transition to CPT modifier 93 to create clarity around the use and outcomes of audio-only communications technology. We agree that this modifier will simplify billing for these services. We also believe the use of this modifier will facilitate research examining the use of audio-only communications technology and help policymakers understand both the clinical benefits and the possible limitations of this type of care.

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

The Alliance supports the proposals from CMS to provide greater flexibility for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to furnish mental health telehealth visits, including via audio-only interactions. Specifically, we are supportive of the delay of in-person requirements under Medicare for mental health services furnished through telehealth under the PFS and for mental health visits furnished by RHCs and FQHCs via telecommunications technology for a 151-day period beginning on the first day after the end of the PHE for COVID-19.

In previous comments on the fee schedule, the Alliance has encouraged CMS to provide similar rural flexibility for Critical Access Hospitals. We applaud the inclusion of provisions to this effect in the *CY2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule*. These permanent expansions of telehealth access will ensure that patients can continue to receive telemental health services from hospitals after the end of the public health emergency.

Telehealth Facility Payment Rate

There continues to be a widespread misconception that telehealth is offered by different, remote telehealth providers and that it is not simply a part of an ongoing care plan that includes in-person care. We know this to be false. The [Telehealth Impact Study](#), an initiative of the COVID-19 Healthcare Coalition, surveyed patients about their telehealth usage and found that 90.9 percent of seniors ages 65 or older indicated that they had seen their own provider or another provider in their provider's practice through telehealth. This telehealth care was used to strengthen the patient-provider relationship and ensure continuity of care throughout the pandemic – and it would have the same effect after.

Understanding that nearly all Medicare beneficiaries received telehealth from their own providers also shines light on the providers offering this telehealth service. Nearly all Medicare fee-for-service (FFS) telehealth was with patients who also utilized in-person care, and nearly all Medicare FFS telehealth was provided by providers who also offered in-person care. That means that telehealth is being offered as a service to Medicare beneficiaries, but it is not in any way reducing practice expenses for those providers.

If CMS acts to limit payment rates for non-facility providers to the facility payment rate for telehealth, it will create a perverse incentive for providers to bring patients into the office for a higher non-facility payment rate – even if the patient could be well served by a telehealth appointment.



In CY 2021 CMS began to modernize its payment structure by evaluating more care on a time-based standard, recognizing that clinician time – both during the visit and through related activity – was the primary determinant related to payment rates. Paying the same clinician different amounts for the same care based simply on the modality of that care would seem to run counter to the understanding that the clinician’s time in caring for the patient is the crucial variable.

A payment structure that discourages telehealth offered by clinicians in the community also directly undermines the Administration’s stated goals of strengthening access to primary care for all Americans, as this will reduce the capacity of those providers to meet patient needs when there are barriers to in-person access. The Alliance for Connected Care encourages CMS to consider payment models that are modality neutral and are based on the value of the clinical service being offered to the patient.

Direct Supervision Via Telehealth

CMS has again requested comment on the use of telehealth for direct supervision. The Alliance for Connected Care continues to strongly support the continued use of direct supervision via telehealth for practitioners unable to bill a service directly to Medicare. Virtual supervision has been crucial during COVID-19 to maintain safety and social distancing for care teams while practicing together, but it has many important use-cases beyond the pandemic. Virtual direct supervision through telehealth can support innovative home-based care models, can expand workforce capacity, and will of course have utility in any future outbreak or public health emergency situation. Virtual supervision is crucial to the transformation of our health care system – from one in which patients sit in offices and wait, to one that meets patients and their needs when and where they are. Without virtual supervision, many of the incredible capabilities that our health care system demonstrated since 2020 will return to their pre-pandemic status quo.

It is also incredibly important to allow virtual supervision of residents by teaching physicians in the academic medical setting – to allow medical students to learn in the field and directly support disadvantaged populations in both urban and rural settings. It is also important to help ensure areas without medical schools are able to build and support the health care workforce they desperately need. 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 thanks CMS for allowing remote therapeutic monitoring (RTM) for an expanded list of providers, such as speech language pathologists, licensed clinical social workers, and marriage therapists. However, the proposed G codes significantly decreases the practice expense for the proposed GRTM 3 and GRTM 4 codes by removing the clinical staff inputs. This represents an almost 40 percent payment reduction for the first 20 minutes of RTM treatment management services and another 24 percent payment reduction for the second 20 minutes. The practical impact of this change would create a significant disincentive for PTs/OTs to perform RTM services and therefore, undermines one of CMS’ aims to increase patient access to RTM services.



Secondly, there are new parenthetical requirements that codes “98975 and 98976 or 98977” (the set-up/education and device supply codes) must be billed prior to billing the proposed new G codes GRTM 1/2/3/4 and that 16 days of data are required. The Alliance for Connected Care is concerned about this proposal, as it prevents clinicians from starting a patient on RTM services in the middle of the month. Additionally, providers will not know whether 16 days of data are achieved until the end of the month, but will need to continue ongoing treatment management services from the beginning of the month and throughout the month. This puts providers at a significant risk of not being paid at all. Additionally, the mandate of requiring 16 days of data collection as a prerequisite to payment, including before a RTM professional code may be billed, is arbitrary and fails to account for various clinical scenarios where 16 days is an inappropriate measure (e.g., action may need to be taken prior to the 16 days for clinical reasons that would limit the duration). We ask CMS to reconsider these provisions to ensure that patients are not facing barriers in access to care. CMS should also consider a patient’s documented individual treatment plan where less (or more) days of data collection might be warranted.

Finally, as CMS rejected calls for a generic device code, RTM management services are thereby limited to two medical specialties – musculoskeletal and respiratory. This precludes the treatment of other conditions where other devices were used to collect the data. We encourage CMS to expand the use cases and potential for RTM, including situations that are not device-dependent.

Chronic Pain Management and Treatment via Telehealth

The Alliance for Connected Care believes that CMS should preserve the ability of the provider to use their clinical judgment on if in-person care is needed for the patient or if telehealth can be used for initial and subsequent visits. Telehealth is a modality to increase access to care and the decision to have an initial telehealth visit should be a decision made by the provider and the patient. Depending on the condition, it may be difficult for patients to be transported to the appointment. Telehealth allows an opportunity for patients to access their care from the home without being barred by their condition.

Additional Guidance Requested

We urge CMS to address provider enrollment concerns that will actively undermine the ability for telehealth to strengthen the health care workforce. During the COVID-19 PHE, CMS allowed practitioners to render telehealth services from their home while continuing to bill from their currently enrolled location. Unfortunately, this policy is set to expire at the conclusion of the PHE – meaning many telehealth providers will be required to report their home address as their practice location for both enrollment and billing purposes. We are concerned that the requirement to publicly report, and have CMS publicly disclose, a home address creates huge privacy and safety concerns for these clinicians. 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.

Furthermore, we encourage thoughtful consideration of the implications of telehealth on providers – not just patients. All of the conveniences that telehealth provides for patients, should also be afforded to providers. 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 zero percent, 51 percent, or 100 percent virtual care) are associated with a clinic that has a primary address. The associated address for that clinic represents the “operational structure.” Therefore, the infrastructure has little to do with where the provider is located physically during the virtual visits.

The Alliance greatly appreciates the leadership from CMS 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 CY 2023 Medicare Physician Fee Schedule proposed rule, 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".

Krista Drobac
Executive Director
Alliance for Connected Care